Republic of Zambia
Ministry of Health

MINISTRY OF HEALTH, ZAMBIA MENTORSHIP TRAINING PACKAGE PARTICIPANT MANUAL

A manual intended for all those involved or prospecting to become mentors.
First Edition, September 2011

Foreword

The provision of quality health care for all Zambians has remained the government's priority for many years. The Government of the Republic of Zambia (GRZ) sought to promote improved health care of its people through the health reforms of 1993. At this time, the Ministry of Health (MOH) proposed that the entire health care service be propelled by the vision**, "Provision of quality and cost effective health care as close to the family as possible."** This vision has remained true to-date. This is exemplified by the numerous developments that have taken place in the health sector in the recent past. Notable are the improvements in the diagnostic and management of non-infectious diseases such as cancer, in which a new cancer hospital has been opened in Lusaka. This, it is hoped, will reduce the cost of sending patients abroad for treament. Many hospitals have been built across the country in order to bring health services very close to the people. New health training schools have also been opened in order to raise the much needed human resource capital base, thereby contributing towards steming the exisiting ***human resource crisis*** in Zambia.

The priority that the government has placed on human resources in the health sector stems from the recognition that the world has become a global village. As such it is expected that the disease burden shall continue to change with global human interaction coupled with changing life stlyes. The steadily rising population has also compelled government to ensure that more skilled human resources capable of handling various health challenges are put in place. The approaches for building such resources must also change with time.

The ministry is convinced that, while its workforce comprises highly qualified and experienced health care providers, there is need to ensure that this workforce is kept up-to-date with the ever changing approaches in the way patients are managed for various ailments. As such, continuous professional development programmes of in-service nature have become a priority. One of the community professional develoment strategies is mentorship. This is a workplace, Competence -Based Training (CBT), that is principally provided by a highly competent, experienced individual (mentor) to another qualified individual (mentee), based on identified performance needs. The mentee, while qualified in a given area may require to either learn new ways of doing the same task or even improve on performance of existing tasks and procedures. The interaction between a mentor and mentee results in cultivation of not only professional values, but also added knowledge and skills. The focus is on developing improved knowledge, skills and attitudes.

This mentorship curriculum takes cognisance of the fact that while health care providers are experts in their own right in their specialities, most may not be good teachers and mentors, with ability to transfer knowledge and skills and change attitudes to others. Therefore, the curriculum focuses first on teaching skills that result in a mentor being able to understand the basics of facilitation, communication, conflict management, critical thinking and clinical teaching before s/he can confidently be able to train and mentor others.

This training package is meant to be read together with the guidelines to mentorship to help both mentors and mentees understand the salient aspects of the mentorship programme and processes. The guidelines provide, among other things, the way the mentorship programme is organised in Zambia, eligibility for mentorship (mentor and mentee), roles of mentorship teams and the tools in mentorship.

I hope that those that will undergo this training will certainly be accomplished mentors so that ultimately skills development in health service provision may reach the desired heights for high impact health service delivery.

The ministry will fully support this programme and recognises it as the most comprehensive mentorship training within the health sector. It is my hope that it will translate into good quality health care services. A skilled and well informed health care provider is certainly a motivated worker and it is my hope that those that will undergo mentorship under this new curriculum will carry out their work with absolute confidence.

Hon. Joseph Kasonde, MP
Minister of Health

MINISTRY OF HEALTH

Table of Contents

Abbreviations

ACNM	American College of Nurse Midwives
ANC	Ante-Natal Care
ARH	Adolescent Reproductive Health
ART	Antiretroviral Therapy
ARVs	Anti-Retroviral
BP	Blood Pressure
CBoH	Central Board of Health
CBT	Competence-Based Training
CCO	District Clinical Care officer
CCS	Clinical Care Specialist
CCT	Clinical Care Teams
CI	Chest In-drawing
CIDRZ	Centre for Infectious Disease Research in Zambia
CNS	Central Nervous System
CRS	Catholic Relief Services
CVS	Cardiovascular System
DANIDA	Danish International Development Agency
DHO	District Health Office
DIM	District Integrated Meetings
DTSS	Directorate of Technical Support Services
EmONC	Emergency Obstetric and Neonatal Care
FEFO	First- Expiry- First- Out
GNC	General Nursing Council
GRZ	Government of the Republic of Zambia
HCW	Health Care Worker
HIV	Human Immuno-deficient Virus
HMIS	Health Management Information System
HPCZ	Health Professions Council of Zambia
HRIT	Health Reforms Implementation Team
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Therapy
JSI	John Snow Inc.
L&D	Labour and Delivery
LMIS	Logistic Management Information System
LMP	Last Menstrual Period
MCH	Maternal Child Health
MD	Medical Doctor
MOH	Ministry Of Health

MSL	Medical Stores Limited
NO	Nursing Officer
NVP	Nevirapine
OI	Opportunistic Infection
PA	Performance Assessment
PC	Performance Criteria
PCP	Pneumocystis Carrini Pneumonia
PEP	Post Exposure Prophylaxis
PHO	Provincial Health Office
PIA	Performance Improvement Approach
PIM	Provincial Integrated Meeting
PITC	Provider Initiated Counselling and Testing
PMO	Provincial Medical Officer
PMTCT	Prevention of MotherTo- Child Transmission
PPH	Postpartum Haemorrhage
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement
RCQHC	Regional Centre for Quality of Health Care
RDT	Rapid Diagnostic Test
RN	Registered Nurse
RR	Respiratory Rate
RS	Respiratory System
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
TB	Tuberculosis
Temp	Temperature
TPR	Temperature Pulse Respiration
TQM	Total Quality Management
TSS	Technical Support Supervision
TWG	Technical Working Group
UFC	Under- Five Card
USAID	United States Agency for International Development
UTH	University Teaching Hospital
ZISSP	Zambia Integrated Systems Strengthen Programme
ZPCT	Zambia Prevention Care and Treatment Programme
ACNM	American College of Nurse Midwives
ANC	Ante-Natal Care

Acknowledgments

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I also wish to express my sincere gratitude to the team of individuals who individually and as a team provided the most valuable input towards the development of this curriculum. The commitment that the respective organizations and individuals put in has resulted into this unique generic document that I am confident will go a long way in improving the quality of health care provision in Zambia.

I wish to extend my special thanks to Dr. Pauline Musukwa-Sambo for the final editing and formatting of the manual.

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To all, I wish to say well done.

Dr. Peter Mwaba
Permanent Secretary
Ministry of Health

Course Overview

 **Duration: 30 minutes**

Specific Objective:

At the end of this session, you should be able to:

- Explain general information on the course

Introduction

Mentoring is a challenging task that requires flexibility, skills in coordinating disparate stakeholders, excellent communication and relationship-building skills and the ability to cope with rapid change of direction, in addition to possessing up-to-date clinical knowledge and teaching skills. This training course on basic mentoring aims at ensuring that clinical mentors are well prepared for their work.

Topics covered within this course include giving feedback effectively, rapport building, bedside teaching, addressing systems issues, starting a mentoring programme by setting up Clinical Care Teams (CCTs) and accessing clinical resources. Sessions are designed based on principles of adult learning, with *competence-based skills transfer approaches.* Therefore a variety of participatory approaches have been adopted to include practical exercises, role plays, brainstorming and other adult learning strategies.

The generic mentorship training course is a specially designed programme with an aim to imparting knowledge, skills and attitudes necessary to ensure that mentors are able to transfer skills to their mentees in a professional and enabling work atmosphere. This module in particular, will provide you with general information on what mentorship is and how the course is organized.

Goal and Objectives

Goal

Provide mentoring knowledge and skills and demonstrate proper attitudes to health care workers in order for them to become effective clinical care mentors.

Objectives

At the end of the course, participants will be able to:

- Explain concepts of mentorship and define the terms used in mentorship
- Apply principles of teaching and learning that can be used during the mentorship process
- Use appropriate strategies to build relationships and prevent conflicts among mentees, peers and other people within and outside the health care system
- Apply critical thinking principles in investigating and managing patients, clients and health and non-health challenges
- Employ clinical teaching skills to interact and mentor mentees successfully
- Follow subject specific mentorship tools to ensure a smooth clinical mentorship process.

How is this Course Organized?

The design of this course reflects that participants are professional health care workers who are well-qualified and who may have a wide variety of experience in the field of clinical mentoring. A variety of approaches to teaching and learning will be adopted, with the underlying assumption that participants are adult learners who will take considerable responsibility for their own learning. The focus will be on active learning and should emphacise the key knowledge and skills needed for individuals who will be serving as mentors.

The course is a facilitator-led programme and consists of sessions within modules and field practice. Sessions include the following teaching and learning methods:

- Lectures
- Case studies
- Role plays
- Demonstrations
- Large and small group discussions
- Individual work

On average, sessions will last between one and three hours. You will receive a morning, lunch, and afternoon break if the training is all day.

The knowledge and skills that participants bring to the course are important to the learning process, and participants are encouraged to share their knowledge and skills and to raise issues that may be challenging to mentors.

What Norms and Expectations will Apply during the Training Course?

To ensure that time spent at the training is both productive and enjoyable, there are some rules and procedures that you will be asked to follow. These are called norms. The following information includes details on general procedures of the course and requirements for completing it. These ground rules are not meant to constrain you but to contribute to a quality learning environment for everyone.

Determining group norms

Your facilitator will lead a brainstorming exercise at the beginning of the course to establish group norms.

Identifying expectations

At the beginning of the course you will be asked what your expectations are of this course. This again is to help your facilitator address these as a point of need as well as guide you along the way so that your interaction with the facilitator is cordial.

How Do I Use this Manual?

The participant handbook was developed to assist you and enhance learning as you participate in the course. The manual contains the following information:

- Course organization including the training schedule
- Seven modules supported by:
    - Worksheets
    - Handouts
    - An accompanying graphics booklet containing copies of PowerPoint slides which can also be provided in soft copy form.

Refer to this participant manual frequently throughout the course. The facilitators will refer to it during each course session.

How Can I Learn Most Effectively in this Course?

There are five important things that you can do as a participant to help create an effective learning atmosphere for yourself, all course participants, and facilitators.

Help to build an atmosphere of trust and support

One of the best ways to help build an atmosphere of trust and support is to listen thoughtfully to the ideas of other participants and provide constructive feedback that will help improve the learning for everyone. Let someone know if they've said or done something that you like. Help a fellow participant or facilitator if you see he or she is having a challenging moment. The best learning takes place in a human environment; help us to build one!

Maintain a positive attitude

There will be times during the course when you might say to yourself, "I'm so tired!" That's okay to say because you will be working hard and expending a lot of energy learning new things. But try to stay positive and productive as you participate in each session. Negativity does not support a quality learning environment.

Contribute to the learning of others

Participants are the most valuable resource in a training course. They help each other learn through sharing relevant work experiences and providing different perspectives. If you see yourself and your fellow participants as resources, you will learn so much more than if you rely solely on the course facilitators for learning the course content. Ask other participants questions, engage them in conversation, and consider sharing relevant examples from your own work experience.

Participate actively

A common assumption is that an active participant in a training course is someone who talks a lot. Not true! Participating actively actually requires more listening than talking. Looking at an individual as they are speaking, nodding your understanding, or using facial expressions that indicate "I'm listening" are active forms of listening.

Another way to actively participate in this training course is to contribute ideas during group exercises, answer questions posed by the facilitators, and ask your own questions of participants and facilitators. In short, participating actively means that it is apparent to others that your brain is on and attentive to each session's activities.

Provide useful feedback at the end of the day

Because we believe that your perspective about how this course is progressing is crucial, we will ask you to give us feedback on each day's session. Your enjoyment, learning and understanding of the day's content will be the main focus of this feedback and should not take you long to complete. Please do provide us with this feedback so that we can monitor and evaluate the progress of the course.

Core Competencies

The course focuses on addressing the following domains of learning:

- Cognitive domain (knowledge development)
- Psychomotor domain (skills development)
- Affective domain (attitude development)

The competences desired for the mentor to acquire in each of the three domains are listed below:

Cognitive domain	Psychomotor domain	Affective domain
• Define clinical mentorship and related terms and concepts • Explain the benefits of clinical mentoring • Describe how to build a positive relationship with a mentee • Explain how the principles of adult learning theory apply to clinical mentoring • Describe the principles of critical thinking • Discuss strategies for addressing common systems issues at health care facilities	• Identify mentoring strategies • Demonstrate effective feedback and communication skills • Apply the domains of learning to clinical mentoring • Choose the appropriate mentoring strategy for a given teaching intervention • Apply critical teaching skills in a mentoring setting	• Reflect on personal motivations and beliefs about mentoring • Keep abreast with key technical matters of medical practice

Teaching and Learning Strategies

This course is organized on the assumption that participants are professional health care workers who are well qualified and who may already have a wide variety of experience in the field of clinical mentoring. A variety of approaches to teaching and learning will be adopted with the underlying assumption that participants are adults who take considerable responsibility for their own learning. The focus will be on active learning and should emphacise the key knowledge and skills needed for individuals who will be serving as clinical mentors.

In order to deliver the entire training course, the sessions may be completed over a period of five days. Generally sessions have been designed to last between one and four hours depending on:

- The participants' previous experience as well as the background knowledge about the concepts being covered.
- Presence of new participants who are not well familiar with mentoring basics.

It must be remembered that this is a Competence-based Training (CBT) Programme and therefore, depending on the participants' levels of prior learning, this course may be administered in its full entirety or you may go straight to specific modules (if you have a participants group that you evaluate as having covered enough of some content within this curriculum). Therefore, documentation of prior learning forms an important component of this training. This approach saves both on time and resources.

Training Environment

Mentoring is a predominantly work-based training system. Therefore, as much as possible this training should be undertaken in close vicinity of a health care facility where both the trainee mentor and the trainer have immediate access to the day-to-day work realities for immediate application.

Participant Eligibility

To undergo training in mentorship, one should have a qualification in any area of a health discipline from a recognised training institution. They should be active practitioners of the respective profession at the

time of entry into the programme. Demonstrated interest to undergo mentorship training will be an added advantage.

Module and Session Layout

Modules 1-3 are more structured and therefore may require that they are followed exactly as laid out. They give an overview of mentorship, general principles of teaching and learning and principles of communication and conflict management. These are more educational and informative modules for learners

Modules 4-7 set the pace for clinical mentorship skills. They introduce participants to general principles of critical thinking which will be necessary when dealing with patient diagnosis and management. Clinical teaching skills which directly apply to clinical and health settings are also included. Module 6 gives learners information on the clinical mentorship process and module 7 provides the tools during the training of clinical mentors and during mentorship.

Module number	Module name	Session # and title
1	Introduction to Clinical Mentorship	*1.1 Definitions and concepts* *1.2 Rationale for clinical mentoring* *1. 3 The role of the clinical mentors* *1.4 Components of mentoring* *1.5 Challenges of mentoring*
2	General Principles of Teaching and Learning	*2.1 Adult learning principles* *2.2 Writing training objectives* *2.3 Learner motivation* *2.4 Active and passive learning and learning styles* *2.5 Teaching and learning approaches and methods*
3	Building Relationships & Conflict Management	*3.1 How to build a mentor mentee relationship* *3.2 Communication skills* *3.3 Practicing affirming statements* *3.4 Conflict management*
4	General Principles of Critical Thinking	*4.1.Scientific models of thinking* *4.2 Clinical thinking and reasoning* *4.3 The problem solving approach*
5	Clinical Teaching Skills	*5.1 Clinical teaching skills*
6	Clinical Mentorship Process	*6.1 What is a mentorship process*
7	Mentorship Tools	

Anonymous Question Box

Some questions are difficult to ask in a group. A box will be set up for participants who have a question they don't want to ask publicly; they can write it down and place it in the box. Questions may include concerns about you, your families, co-workers and patients.

The bowl will be checked each day before lunch and the questions read outloud to the group. You will be given time to think about the questions, and your facilitator will lead a discussion after lunch to allow participants to share their thoughts.

Programme Evaluation

Programme performance shall be evaluated at two levels:

Mentee evaluation: Mentees will evaluate the mentorship programme at the end of its full duration using a specific evaluation tool. They shall assess both the mentor as well as the programme inputs as the basis for future programme improvement.

Programme evaluation: The mentor will assess the entire mentorship process using a tool designed in an end report format. This report will be submitted to facility management, MOH and other relevant partner organizations.

As appropriate, the programme may be reviewed, incorporating pertinent inputs from both mentees' and end report assessments

Mentorship Course Schedule

Day	Time										
Monday	08:15 – 09:00	09:00 – 09:30	09:30 – 10:30	10:30 – 10:45	10:45 – 11:30	11:30 – 13:00	13:00 – 14:00	14:00 – 15:30	15:30 – 15:45	15:45 – 16:45	16:45 – 17:00
	Registration, Welcome, House - keeping, Official Opening	Course Overview	Module 1: Introduction to Clinical Mentoring	Tea	Module 1: Introduction to Clinical Mentoring	Module 2: General Principles of Teaching and Learning	Lunch	Module 2: General Principles of Teaching and Learning	Tea	Module 3: Building Relationships and Conflict Management	Day Evaluation
Tuesday	08:15 – 08:30	08:30 – 10:30	10:30 – 10:45	10:45 – 11:30	11:30 – 13:00	13:00 – 14:00	14:00 – 14:30	14:30 – 15:45	15:45 – 16:00	16:00 – 16:45	16:45 – 17:00
	Recap	Module 3: Building Relationships and Conflict Management	Tea	Module 3: Building Relationships and Conflict Management	Module 4: General Principles of Critical Thinking	Lunch	Module 4: General Principles of Critical Thinking	Module 5: Clinical Teaching Skills	Tea	Module 5: Clinical Teaching Skills	Day Evaluation
Wednesday	08:15 – 08:30	08:30 – 09:30	09:30 – 10:30	10:30 – 10:45	10:45 – 13:00	13:00 – 14:00	14:00 – 15:45	15:45 – 16:00	16:00 – 16:45		16:45 – 17:00
	Recap	Module 5: Clinical Teaching Skills	Module 6: Clinical Mentorship Process	Tea	Module 7: Mentorship Tools	Lunch	Module 7: Mentorship Tools	Tea	Module 7: Mentorship Tools		Day Evaluation
Thursday	08:15 – 08:30	08:30 – 10:30		10:30 – 10:45	10:45 – 13:00	13:00 – 14:00	14:00 – 15:45	15:45 – 16:00	16:00 – 16:45		16:45 – 17:00
	Recap	Facility Based Mentoring Practical		Tea	Facility Based Mentoring Practical	Lunch	Facility Based Mentoring Practical	Tea	Facility Based Mentoring Practical		Day Evaluation
Friday	08:15 – 08:30	08:30 – 10:30		10:30 – 10:45	10:45 – 13:00	13:00 – 14:00	14:00 – 15:45	15:45 – 16:00	16:00 – 17:00		
	Recap	Facility Based Mentoring Practical		Tea	Facility Based Mentoring Practical	Lunch	Facility Based Mentoring Practical	Tea	Course Evaluation, Closing and Way Forward		

Module 1.0: Introduction to Clinical Mentorship

 **Duration: 1 hour 45 minutes**

1.1 Module Objectives:

At the end of this module you should be able to:

- Describe the principles and rationale of mentorship

Session Plan for Module 1

Time	Session	Facilitation and active learning strategies
20 minutes	Definitions and concepts	Presentation Interactive question and answer
10 minutes	Rationale for mentoring	Presentation Interactive question and answer
20 minutes	The roles of mentors	Interactive question and answer Brainstorming
15minutes	Components of mentoring	Presentation Interactive question and answer
40 minutes	Challenges of mentoring	Interactive question and answer Brainstorming

1.2 Introduction

Mentorship is a form of training with special emphasis on direct transfer of skills from a highly experienced and competent practitioner to another less competent practitioner. Mentorship assumes existence of a workplace setting where the participant, called mentee, practices on real life work situations. In some cases though, non-real situations may also be employed.

In all cases, there is a very close relationship between the mentor and the mentee. The mentee must do what the mentor does, preferably to the same standard and proficiency level. This kind of learning is also referred to as "learning by doing" and competence based. The mentee learns by a process referred to as "*sitting by Nelly*". What "Nelly" does, mentee must do.

Mentorship uses several delivery approaches such as role plays, demonstrations, simulations, brainstorming and other practical based strategies for immediate transfer of skills and value

Session 1.1 Definitions and Concepts

Specific Objective:

At the end of this session, you should be able to:

- Define the concepts of mentorship and explain the terms used in mentorship

Overview

Definitions and concepts of mentorship will help you understand the technical aspects of mentorship and apply them when you learn principles of teaching and learning. We have included most of the definitions and concepts that we are sure you will come across in this course. Pay attention to these and master them before you progress to subsequent modules.

Definitions and Concepts

Active learning: In active learning the learner is involved or participates in the learning such as through discussion or doing a role play.

Adult Learning Theory: Adult learning theory refers to a set of ideas about how adults learn new skills or information.

Brainstorming: Brainstorming is a technique in which the group gives suggestions or solutions to a problem or situation.

Case study: A case study is a description of a person or situation that is studied to decide on the best plan of action to take.

Dale's Cone of Learning: Dale's Cone of Learning refers to a cone-shaped graphic that shows that when learning is active, more is remembered than when learning is passive.

Demonstration: A demonstration is a way of showing how something is done.

Engagement: Engagement is actively participating in learning tasks.

Immediacy: Immediacy is the direct usefulness of the learning to the learner.

Interactive learning: Interactive learning actively involves the learner in the learning experience.

Mentor: Someone who guides another individual (mentee).

Mentee: Someone who is guided by an experienced person.

Trainee mentor: Someone who is being trained to become a mentor.

Mentorship: Mentorship is the process whereby an experienced, highly regarded empathetic person (mentor) guides another individual (mentee) in the development and re-examination of their own ideas, learning and personal and professional development.

Mentoring: The active process of offering mentorship.

Mentorship may be further classified as:

- **Structured/formal/facilitated mentoring:** Mentor/mentee pairs are assigned to one another, usually for a specified amount of time.
- **Classical/unstructured/informal mentoring:** Occurs when two parties are drawn together naturally by their personal characteristics, attributes and common values.

Motivation: Motivation is what gets people interested or involved in learning.

Non-verbal cue: A non-verbal cue is a message that does not use words, such as facial expression, posture or eye contact.

Passive learning: In passive learning the learner gets information by seeing and/or hearing.

Relevancy: Relevancy is the usefulness, importance, or applicability of the learning to the learner.

Respect: Respect is to show consideration for the learner.

Role play: A role play is a situation in which two or more people act out a scene.

Safety: Safety is creating a learning environment and a learning design that feels comfortable and safe for the learner.

Session 1.2 Rationale for Clinical Mentoring

Specific Objective:

At the end of this session, you should be able to:

- Explain the rationale behind clinical mentoring

The following are the rationale behind clinical mentoring:

Decentralization

Mentoring allows the decentralization of quality health services from tertiary institutions to district hospitals and health centres. Mentoring can help build the capacity of health workers in district facilities to provide services previously restricted to specialized referral centres.

Task shifting

Tasks can be shifted from the more-specialized to less-specialized health care workers.

Standardized content and care pathways

A mentoring system reinforces the use of standardized, simplified clinical protocols and operating procedures. Such protocols should be displayed and easily referenced.

Continuing education

By and large, there is little follow-up of trainees after initial training. Mentoring provides a platform where trainers are in a life-long relationship with their trainees and education is an on-going process.

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Session 1.3 Roles of Clinical Mentors

Specific Objective:

At the end of this session, you should be able to:

- Describe the roles of a clinical mentor

Participant Assignment:

As a group, brainstorm with the facilitator on the roles of clinical mentors. Then discuss how each of the roles stated in this session below will improve the quality of a mentorship encounter.

Overview

As a trainee mentor, it is important that you master your roles as they form the basis of your success as a mentor. You may wish to discuss each of these principles with your peers so that you gain mastery of these roles.

Building relationships

Establishment of a trusting and receptive relationship between the mentor and mentee (s) is the foundation for an effective mentoring experience. This component is ongoing over the course of the mentorship, as the relationship continues to evolve and grow.

Identifying areas for improvement

This component involves observation and assessment of existing systems, practices, and policies to identify areas for improvement. Information obtained during this assessment helps to inform the establishment of goals and objectives for the mentorship.

Responsive coaching and modeling of best practices

Mentors must demonstrate proper techniques and model good practices. For example during on-site mentoring, this means examining patients along with the mentee; using appropriate, systematic examination techniques with gloves when appropriate; and hand washing. Mentorship is as much about setting a good example as it is about directly intervening to improve mentee practice.

Advocating for environments conducive to quality patient care and provider development

This component relates to technical assistance in support of systems-level changes at the site. Mentors work with colleagues to enhance the development of clinical site infrastructure, systems, and approaches that can support the delivery of comprehensive health care. For example, mentors might provide technical assistance in support of the proper flow of patients at the facility, advocate for provision of privacy for patients during examination, gender mainstreaming in health service delivery, or help to promote a multidisciplinary approach to health care at the site.

Collecting and reporting on data

Mentors support the use and integration of patient data into clinical practice, and can help to demonstrate the utility of data collection and reporting to mentees during the mentorship. For example, ensuring that all patients seen are tallied correctly enables the correct analysis of facility data for decision making.

Session 1.4 Attributes of Mentors

Specific Objective:

At the end of this session you should be able to:

- State the attributes of mentors

These are the components of mentoring:

Knowledge base

The clinical mentor should have a sound knowledge base. It is crucial that the mentor has up-to-date information, with a solid base of knowledge about disease management, as care and treatment approaches change rapidly. There are also important components outside clinical knowledge.

Relationship and genuine presence

What you do as a mentor is guided by a good relationship. You must be fully present and empathetic, and find ways to connect to the mentee. Building this relationship may take time and is an ongoing process, even over years of working together. It is important to communicate to the mentee that you are readily available. Keep in mind that you are a guest in their space, and this should be respected always.

Observation over time

As a mentor, you must begin by paying attention. You are making careful observations about what is already going on at every level. This means learning about the culture and the setting you are visiting.

You observe the system of care, the teamwork among the staff, and the knowledge and clinical skills of the ones you are mentoring. For each team member there are skills to observe. For example:

- How does the pharmacist educate the patient?
- How does the counselor teach adherence?
- How does the receptionist help the new client feel comfortable?

There may be opportunities to discuss stigma, confidentiality, etc. These are subtleties that are important to recognise when you are mentoring. For example, how does the health care worker greet the next patient? Does s/he just yell out the name of the next patient or does s/he walk out to greet them?

Active listening

Beyond your observations, you must be actively listening. This means paying attention to the patient, and colleagues. Mentors must listen without judgment.

Interactions

Mentors are role models all the time:

- How you approach patients and colleagues will be noticed.
- In each interaction your relationship and communication skills are crucial.

Feedback is given from mentor to mentee, but also from mentee to mentor. Mentors are always learning; the learning does not stop when you are a mentor.

Other attributes of a clinical mentor include the following:

- **Be informed**

  Gather data about your mentees.

- **Be optimistic**

  Don't let disinterest, shyness, antagonism, cynism, or other negative reactions throw you off.

- **Be consensual**

  Always strive to create outcomes that reflect ideas of all mentees equally.

- **Be flexible**

  To be a successful mentor, always have a process plan for all meetings. However, you should also be ready to adjust based on legitimate need. It may be helpful too, to equip yourself with an alternative strategy.

- **Be understanding**
- **Be alert**

  Take note of how people interact and achieve their tasks.

- **Be firm**
- **Be gender sensitive**

Below are some practices that you need to be aware of as a mentor:

Best Practices	Worst Practices
• Carefully assess the needs of members • Probe sensitively into peoples' feelings • Create an open and trusting atmosphere • Help mentees understand why they are there • View yourself as serving group needs • Gender sensitive • Make mentees the centre of attention • Speak in simple and direct language • Work hard to stay neutral • Display energy and appropriate level of assertiveness • Treat mentees as equals • Stay flexible and ready to change direction as necessary • Listen critically to fully understand what is being said • Take notes that reflect what mentees mean • Ensure that mentees feel the ownership of what has been achieved	• Remain detached from what mentees think or need • Never checking mentees concerns • Fail to listen carefully to what is being said • Lose track of key ideas • Take poor notes or change the meaning of what is being said • Lose track of key ideas • Try to be the centre of attention • Get defensive • Get into personality battles • Put people down • Avoid or ignore conflict • Let a few people or the leader dominate • Be overly passive on process • Have no alternative approaches • Let discussions be badly sidetracked • Failure to observe time of activities • Gender bias

Session 1.5 Challenges of Mentoring

Specific Objective:

At the end of this session, you should be able to:

- Explain possible challenges in mentoring and how to address them

Session Instructions:

Form small groups and brainstorm on the possible challenges to mentoring and provide solutions to each of the challenges. Each group should then share with the rest of the participants their discussion points using a flip chart.

Learn the challenges of mentorship in order for you to avoid the pitfalls associated with handling mentees at different times of the mentorship process. The following are some of the challenges the mentor may face:

- **Defensiveness on the part of the mentee:** The arrival of a mentor can be a set up for defensiveness in colleagues, e.g., "What? You don't think I know what I am doing?"
- **Putting up one's best show:** We all like to put on our best when someone is watching, but those are not the "day to day" practices we want to help improve.
- **Timid mentee:** Some health care workers who will be mentored will be timid to an extent such that it becomes difficult to mentor them effectively.
- **Overwhelming workload:** Some sites that mentors will visit will have a large patient load such that the time spent undertaking the actual mentorship is reduced as the mentor may have to spend time helping out seeing patients.

In addition to the challenges, bad practices may also be noted. We need to consider how we will address these bad practices:

What are we to do when we directly observe "bad" as opposed to "best" practices? And what are we to do when we encounter unethical practices? More interpersonal challenges to mentoring will be discussed in the next unit.

Module Summary

- Mentoring helps to decentralize quality health care and provides an opportunity of continuing medical education.
- A mentor should build relationships and advocate for improved patient outcomes.
- A mentor should have a sound knowledge base.
- There may be challenges during mentorship and these need to be recognised and managed appropriately..

Module 2.0: General Principles of Teaching and Learning

 **Duration: 2 hours 45 minutes**

Module Objective:

At the end of this module you should be able to:

- Describe adult learning principles

Session Plan for Module 2

Time	Session	Facilitation and active learning strategies
15 minutes	Adult learning principles	Presentation Interactive question and answer
50 minutes	Writing training objectives	Presentation Demonstration Group work Interactive question and answer
15minutes	Learner motivation	Presentation Interactive question and answer
25 minutes	Active and passive learning and learning styles	Interactive question and answer Brainstorming
55 minutes	Interactive teaching and learning approaches and methods	Presentation Interactive question and answer Brainstorming Role plays Group work

Introduction

Session 1 of this module looks at some of the principles of adult learning theory. It focuses on the theory that adults learn best when they can use their life experiences during the process of their own learning.

In the next session the module gives you information on the teaching and learning approaches that you will need in your role as a mentor. The subsequent sessions strengthen your understanding and applications of motivation, culture diversities and the approaches you may wish to employ in the course of interacting with your mentees..

Session 2.1 Adult Learning Principles

Session Objective:

At the end of this session, you should be able to:

- Explain the importance of applying adult learning principles in teaching adult learners

Overview

This session gives you information on the strategies that are commonly used in teaching adults. This process is referred to as andragogy, quite different from the approaches used in teaching young, school going learners (pedagogy).

Teaching adults is different from teaching children. Generally, children have far less knowledge than their teachers. Thus they depend on their teachers for direction in learning. Adults on the other hand have a lot more experience. They often want to discuss their experiences and also want to decide for themselves what to learn and relate their experiences to what they are learning.

Therefore, the principles used in teaching children may not work well for adults.

Adult Learning Theory and Principles

Theory Definition:

Adult Learning Theory is a set of ideas about how adults learn new skills or information.

Adult learning theory focuses on the idea that adults learn best when they talk to others about their life experiences and relate these experiences to the learning process.

Adult Learning Principles

There are many adult learning principles; but here the focus is on five key principles. **Adult learners need**:

- to be respected,
- to see the immediate usefulness of the learning,
- a safe learning environment,
- to be engaged in their learning, and
- learning to be relevant to their lives.

The table below provides you with more information on the way adults learn. Trainee mentors must master these and apply them later during practical sessions.

Factors that influence adult learning

Factor	Description of Adult Learners
Respect	need to be the subject of their own learning need to be free to decide what to learn like to be part of planning what will happen during the learning
Immediacy	need to see how the learning can be used right away do NOT like to waste time
Safety	need to feel welcome and comfortable during the learning experience need to have trust in the learning design do NOT want to be judged want to be recognised or affirmed
Engagement	need to be actively involved in the learning
Relevancy	relate learning of the topic to their life experiences

Cross culture learning

Adult learners may differ in the way they wish to learn depending on the culture of the participant. What is true for many participants may not be true for all participants.

Not all adult learners value self-directedness. For example it has been reported that, culturally the Japanese look to their teacher for direction and guidance. Self-direction for adults in these cultures may cause anxiety.

Therefore you must be aware of the different cultures the participants are coming from.

Session 2.2 Writing Training Objectives

Specific Objective:

At the end of this session, you should be able to:

- Construct teaching and learning objectives correctly

Overview

This is a practical session. Objective writing is based on Bloom's taxonomy of learning. It includes the three attributes of performance, standard and condition and is a three-step process. You will need to practice constructing educational objectives. Note that generally, learning objectives are written in terms of learning outcomes. Therefore, it is always important for you to ask yourselves what you want learners to learn from the lesson and what you want them to be able to do after going through a lesson.

Domains of Learning Used in Objective Writing

Learning objectives are written based on the three domains of Bloom's taxonomy. The objective that is written indicates what the learning outcome is expected to be; an acquisition of knowledge, a change in attitude,or improvement of skills. The table below describes in detail the features of each domain.

Cognitive (Knowledge)	Affective (Attitudes)	Psychomotor (Skills)
Objectives based in this domain seek the most important underpinning knowledge desired in the session before skills and attitudes may be imparted. Move from simple knowledge (recall type) to more complex processes like synthesis of information and evaluation.	Emphasises feeling, tone or emotion; degree of acceptance or rejection of what is being taught. A health care worker's values, emotions, attitudes and beliefs can have a great impact on the care provided.	Relates to the physical skills and/or performance of motor tasks. Moving from observation to mastery of a skill; performance of a lab test or clinical examination.

Atherton, J. S. (2011), Learning and Teaching: Bloom's Taxonomy

Attributes of an educational learning objective

In addition to demonstrating the learning domains mentioned above, a complete educational objective should possess three attributes:

- **Performance criteria (PC),** e.g., explain, build, etc.
- **Standard**, e.g., accurately, without errors, etc.
- **Condition**, e.g., given a blood collection set

A typical complete educational objective would appear as follows:

Collect a blood sample (PC) from a patient correctly (standard) given the right collection set (condition).

Note however that unless objectives are written by professional educationists or curriculum specialists, complete objectives having all three attributes are rare in most curricula.

Creating Learning Objectives

Learning objectives are created through a three step process. Follow the three-step process below for creating learning objectives.

1. Create a stem. Stem examples:

- *After completing the lesson, the student will be able to . . .*
- *After this unit, the student will have . . .*
- *By completing the activities, the learner will . . .*
- *At the conclusion of the course/unit/study, the learner will . . .*

2. After you create the stem, add a verb:

- *Analyse, recognise, compare, provide, list, etc.*

3. Once you have a stem and a verb, determine the actual product, process, or outcome desired from the learning intervention: e.g., after completing this lesson, the learner will be able to recognise *various surgical equipment used in theatre.*

Below you will find numerous examples of learning objectives used by trainers and facilitators. We have taken examples from science just to make it relevant, and we are sure you will find them useful even when you start writing teaching objectives yourself.

After completing the lesson, the student will be able to:

- *recall information about the reading . . .*
- *develop a basic knowledge of _____ (history taking, etc.)*
- *record and compare facts about _____ (the sun, moon, etc.)*
- *collect, organise, display, and interpret data about _____*
- *create a visual representation of _____ (the HIV life cycle, etc.)*
- *identify states of matter . . . ; create a concept map of . . .*
- *identify relevant questions for inquiry; sequence and categorize information . . .*
- *demonstrate learning by producing a _____*

Exercise:

Follow the facilitator's instructions to divide into groups; each group should create three learning objectives, one from each learning domain. Write these down on a flip chart and present to the rest of the class.

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Session 2.3 Learner Motivation

Session Objective:

At the end of this session, you should be able to:

- Explain factors that may affect motivation and to describe the strategies used in motivating a learner

Motivation is the "why" of behaviour. In this session, factors that may affect learner motivation are explained and strategies used to motivate learners are described. It is your role to ensure that the mentee also understands these factors. Motivation is what gets people interested in learning. If a participant does not feel she or he needs a skill or information, she or he will not pay attention.

Factors affecting learner motivation:

- Adult learning must be autonomous and self-directed.
- Adults need to connect their learning to their knowledge and experience base.
- Adults are goal-orientated--they must perceive the goal they are going to achieve after learning whatever they are learning.
- Adults must see the reason for learning something. The learning must be applicable to their work or other responsibilities to be of value.
- Adults need to be shown respect. Mentors must acknowledge the wealth of their experience.

Strategies to help participants become motivated:

- Be friendly, open, and respectful
- Point out the benefits of learning to the participants
- Make sure the material covered is not too difficult or too easy for the participants
- Encourage participants to say what they want to learn from the session, and
- Give participants the chance to make decisions during the session.

Indicators of participant's readiness to learn

Motivated participants take the information they learn and try to make changes. Poorly motivated participants do not make any changes. In addition, a participant's verbal and non-verbal cues can show you whether or not she or he is motivated to learn (see table below for a list of some of these cues).

Cues indicating motivation to learn

CUE	Motivated to Learn?	
	YES	NO
nods head	√	
smiles	√	
looks “interested”	√	
asks relevant questions	√	
leans forward	√	
shares experiences	√	
tries things on her/his own	√	
adds relevant information on topic	√	
makes eye contact**	√	
looks “not interested”		√
drums fingers		√
shrugs		√
closes eyes		√
looks away		√
stares		√
crosses arms and legs		√
rests head in palm of hand		√
yawns		√
easily distracted		√
comes to class late		√

Note: These may be true for some cultures but not necessarily all cultures. Make sure you understand the cultural diversity of the participants you are working with.

(For example, people of some cultures will NOT make eye contact with the instructor.)

Session 2.4 Active and Passive Learning and Learning Styles

Session Objectives:

At the end of this session, you should be able to:

- Describe the relative advantage and disadvantages of each learning approach
- Describe the relative advantage and disadvantages of each of the different types of passive and active learning approaches
- Explain the different styles of learning

Overview

This is a session meant to give information on how people learn and remember things. You may need to read through this session repeatedly in order to master how retention takes place in everyday life. You will need to use the information to select the most effective skills transfer sessions with your mentees.

Active learning involves participants in the learning. Participation in a discussion, giving a talk or doing a role play are some examples of active learning. We tend to remember more of what we learn actively than what we learn passively.

Participants will have different learning styles. Use a variety of techniques in your interaction with trainee mentors so that you can help them learn more effectively**.**

Learning Methods

There are two methods of learning:

- passive
- active

In ***passive learning***, the learner gets information by seeing and/or hearing. Examples of passive learning methods are:

- reading
- hearing words
- looking at pictures

We tend to forget much of what we learn passively.

In ***active learning*** the learner is involved in or participates in the learning.

Examples of active learning methods are:

- participating in a discussion
- helping others learn
- doing a role play

We tend to *remember* most of what we learn through active learning.

Edgar Dale's Cone of Learning shows how much we remember from different ways of learning. To make your teaching or mentoring as effective as possible you may want to include methods found near the bottom of the cone.

Learning Styles

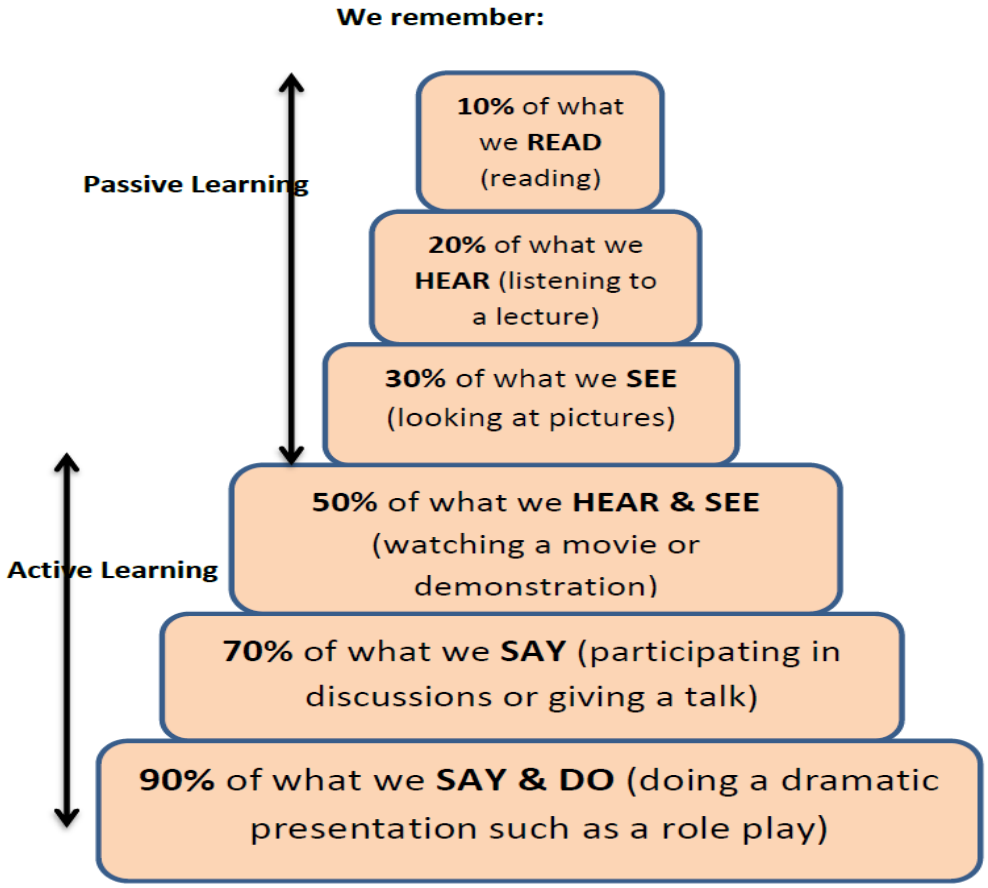
There are different styles of learning and different individuals tend to learn differently. Adults in particular also want to have a say in the way they should learn. Mentors need to take into consideration the different learning styles of the mentees and therefore use a variety of styles in teaching. Mentors must also ensure application of adult learning principles to the different learning styles.

Some learners find it easier to learn if they see a photo or a poster. Others learn best if they can read the information. Others still, may find it easier to learn if they hear someone explain the information. Thus we **do not all learn in the same way.** Your mentees will have different learning styles. Therefore plan your sessions with this in mind. Use a variety of learning techniques so that you can help the different types of learners. The chart below lists some learning styles and an example of a teaching approach for each learning style.

Learning styles and examples of teaching approach

For a person who learns by:	Teaching approach and example
Seeing	Use visuals, for example, show a photo of a variety of foods in nutrition class.
Hearing	Use something the learner can hear. For example, play a song about the importance of breastfeeding.
Tasting	Use something the learner can taste. For example, have participants taste a bitter medicine, e.g., quinine.
Touching	Use something the learner can touch. For example, have the participant feel an enlarged organ, e.g., liver.
Doing	Have participants do a role play.

Edgar Dale's Cone of Learning



Session 2.5 Teaching and Learning Approaches and Methods

Session Objective:

At the end of this session, you should be able to:

- Describe the most common interactive teaching and learning strategies in an adult learning setting

Overview

This session will help you learn the various interactive teaching and learning strategies used in delivering a session. Ensure that you practice all the approaches to appreciate the scenarios in which each may be best applied.

Interactive learning

Definition: Interactive learning actively involves the mentee in the learning experience. **It can be fun and can prevent boredom.**

There are several ways that you can make learning and mentoring fun and interactive. These include:

- brainstorming,
- demonstrations,
- role-playing,
- case studies
- games

Brainstorming

To brainstorm is to solve a problem or make a decision by thinking of as many ideas as possible in a short time. Brainstorming with a group of people is a powerful technique. It creates new ideas, solves problems, motivates and develops teams. Brainstorming motivates because it involves many or all members of a team contributing to decision making and to take part in solving management issues. It gets a team working together. However, it is not simply a random activity but needs to be structured and must follow brainstorming rules.

Brainstorming rules

1. Define and agree on the objective.
2. Brainstorming ideas and suggestions should have an agreed time limit.
3. Categorise/condense/combine/refine.
4. Assess/analyse effects or results.
5. Prioritise options/rank list as appropriate.
6. Agree upon action and timescale.
7. Control and monitor follow-up.

Participant Assignment:

Using brainstorming, give suggestions or solutions to the situation described below. Ensure that you follow the seven steps above.

A 17-year old pregnant adolescent is having a conversation with her mother. The adolescent's mother wants her to breastfeed her baby, and the adolescent believes she should bottle-feed.

Here are some tips to help you use brainstorming:

1. Introduce brainstorming rules, such as:
    - No idea is bad, i.e., there is no wrong or right answer in adult learning.
    - No idea is discussed until everyone has had a chance to speak.
    - Every person gets a chance to speak.
    - Do not judge ideas that come from the group.
2. Write ideas down on a flipchart or blackboard.
3. Write down the exact words of each speaker.
4. When the group has no more ideas to offer, have the group discuss the different ideas.

Demonstrations

A *demonstration* is a way of showing the group how something is done.

Here are some examples of demonstrations:

5. Preparing appropriate equipment to be used in the procedure (s)
    - Using actual items to show how the procedure is supposed to be performed
    - Using models or simulators to represent the actual human being.

Role Play

Role play is defined as an experience around a specific situation which contains two or more different viewpoints or perspectives.

Role playing games, exercises and activities help build teams, develop employee motivation, improve communications and are fun - for corporate organizations, groups of all sorts, and even children's development. Role playing games, exercises and activities improve training, learning development, and liven up conferences and workshops.

In a role play two or more people act out a scene. Models such as dolls for babies may not be needed but may be helpful.

Role plays are good for:

- Trying out a new skill
- Practicing a "real-life" situation.

When developing skills, you should model the skill before the participants do the role plays.

To do a role play the group must be willing to participate. Only use this technique when the participants know each other well enough to feel at ease.

Here are some tips to help you formulate a role-play:

- Be very clear about what you want your mentees to get out of the role play playing experience. "Muddy thinking at the outset will result in muddy outcomes". Clear thinking and role play preparation result in clear outcomes.
- Role plays can be used for assessing skills or for developing skills. Are you assessing skills or are you developing them? Role plays given at the same level of challenge to all mentees is recommended more for assessment, while role plays adjusted according to the level of skill of each individual is recommended for development.
- If you are assessing skills, the mentees need to know the competency level expected of them and the role play brief needs to have measurable outcomes. Mentees also need to trust that the role play will have the same level of challenge for them and their peers. Mentees should not undergo assessment through role play unless you know they have reached the expected standard (through development activities and role plays).

Participant Assignment:

The class must divide into small groups. Each group should carry out the following activities:

1. *Write down a role play. Describe the setting, situation, roles to be played and time to be taken for the role play.*
2. *The facilitator will ask members of the rest of the group to act out the scene.*
3. *The facilitator will ask for reactions from the role-players and then ask the rest of the group to comment on the role play and the adequacy of the brief.*

Case Studies

A case study is an example of a situation or person that is similar to what the participants are learning about. You can use case studies to help the group review what they have learned. Many of the situations that you use for role plays will work well for case studies. Here are some tips to help you use case studies.

- Give group members a short paragraph on a patient who has a specific problem.
- Have the groups discuss the case and suggest a plan of action. You may want to ask some questions to get the group started.

Module 5 provides more details on developing case studies.

Module Summary

- Teaching adults is different from teaching children.
- Adults often want to discuss their experiences during learning.
- Adult learners need to see the immediate usefulness of the learning.
- Training/learning objectives have a performance criteria, standard and condition.
- Different people have different learning styles and these need to be taken into consideration during training or mentoring.
- Keep participants or mentees motivated by engaging them actively according to Dales Cone of Learning.

Module 3.0: Building Relationships and Conflict Management

 **Duration: 4 hours**

Module Objective:

At the end of this module you should be able to:

- Use appropriate strategies to build relationships and prevent conflicts with mentees, peers and other people within and outside the health care system

Session Plan for Module 3

Time	Session	Facilitation and active learning strategies	Facilitation resources
30 minutes	How to build mentor-mentee relationships	Presentation Interactive question and answer	LCD projector Flip chart and markers
1 hour 45 minutes	Communication skills	Presentation Group work Brainstorming Interactive question and answer	LCD projector Flip chart and markers
1 hour 15 minutes	Practicing affirming statements	Presentation Group work Brainstorming Role plays Interactive question and answer	LCD projector Flip chart and markers
30 minutes	Conflict management	Presentation Interactive question and answer Brainstorming	LCD projector Flip chart and markers

Introduction

While a mentor needs very good clinical and teaching knowledge and skills, the ability to develop a relationship and presence with the mentee is critical. Building relationships with mentees is key to a fruitful mentorship.

Session 3.1 How to Build a Mentor-mentee Relationship

Session Objectives:

By the end of this session, you should be able to:

- Explain the importance of building a relationship with a mentee that is based on trust, mutual respect, and an understanding of cultural differences
- Identify techniques for building rapport
- Use effective communication skills in building relationships
- Practice affirming statements
- Identify potential barriers to relationship building

Overview

This session takes you through the basic steps you will require to build a good mentor-mentee relationship. Remember:

- Building this relationship takes time and is an ongoing process, even over years of working together.
- Think about the core values you share with this mentee. Some of these core values may be:
    - Social
    - Cultural
    - Religious
- Communicate to the mentee that you want to be there. Keep in mind that you are a guest in the mentee's space and this should be respected always.

All relationships go through phases. Within mentorship, phases for the mentor-mentee relationship have been identified. An understanding of these phases helps the mentor nurture the relationship so it is most effective and supports the mentee's learning process. A description of the phases of mentoring is provided below.

Phases of Mentoring

There are five phases of mentoring:

- Orientation phase
- Transition phase
- Cultivation phase
- Resolution phase
- Re-definition phase

i) Orientation phase (mentor and mentee meet)

The orientation phase begins with the mentor and mentee first meeting. This may be a meeting of two strangers or two people who are known to each other. They may have developed mental images and value judgments about each other.

It is possible that both the mentor and the mentee have some anxiety which may be communicated to one another. Even though a mentee feels a need, the need may not be identified or understood clearly. The mentee may also be anxious about what the mentor may think of her/him, what is expected and whether s/he will be able to work with the mentor. Will the mentor listen to the mentee? Will the mentor encourage the mentee to work on her/his needs without being made to feel inferior?

The mentor may also be anxious about performing a helping role and worried about rejection by the mentee. The mentor can decrease her/his own anxiety by preparing for their first contact.

In the orientation phase, the mentor gives the mentee some information on who s/he is and what the mentor's purpose is for conducting the mentorship. S/he tries to become oriented to the mentee's goals, needs and expectations of the mentorship and of her/himself. The mentor and mentee begin to work collaboratively to analyse the situation to define feelings, needs, goals and objectives. This may include discussions about:

- Objectives and goals, including mid and final objectives of the mentoring relationship; this is developed by the mentee and mentor together.
- What both sides are willing and capable of contributing to the relationship.
- Needs, expectations and limitations that exist on each side.
- What success would a mentor and mentee most importantly want to get from the relationship.
- Importance of clear and honest feedback, whose overall aim is to make the mentee independent.
- The boundaries of the relationship, such as: How long will the mentorship last? What other issues need to be considered?
- How to work together.
- How to deal with conflict if it arises.
- What confidentiality means. It is not acceptable for the mentor or mentee to tell anyone other than her/his supervisors about their discussions, areas of need identified and solutions discussed.
- Ways of contacting the mentor in between sessions if advice or support is required in a crisis.
- Handling of missed mentor-mentee appointments and how much notice is required.
- Any specific needs of the mentee such as working on confidence and self-esteem and whether the mentor is able to assist with these issues.

At the end of this stage, hopefully both the mentor and mentee can begin to build a personal relationship with feelings of security, respect, trust for one another and understanding.

ii) Transition phase

The transition phase may not take place in all mentoring relationships. Some relationships go directly to the cultivation phase. The transition phase is characterized by testing behaviour of the mentee. The mentee may go back and forth between positive involvement and a tentative relationship with the mentor. This can be difficult for the mentor who may experience frustration at the inability to win the mentee's trust. The result of this phase is that the mentee and mentor move to the cultivation phase and continue with the process.

iii) Cultivation phase

The mentee and mentor have defined the objectives of their relationship within the mentoring programme. Together they become responsible for their mentoring relationship. The cultivation phase is made up of interrelated thoughts, feelings, and attitudes communicated by both the mentor and mentee. The mentor, acting as a mirror, uses a nonjudgmental attitude to provide an accepting, trusting, encouraging, supportive, respectful and positive atmosphere and a healthy learning environment. Through this environment the mentee's skills development is encouraged. The mentee practices critical thinking. As a result of this the mentee becomes more self-aware and begins to see things from a different perspective and better understands:

- Her/his own feelings and thoughts
- Perception of self and others
- How s/he relates to others
- What is her/his own way of doing things
- Ways some of her/his behaviours can cause problems
- How to better cope with problems
- What s/he values
- What support is available to help with problems/issues
- How to handle feelings and issues related to work.

The mentee eventually begins to use her/his actual strengths to minimize weaknesses.

The mentor uses perception skills to understand how the world looks to the mentee. The mentor helps the mentee to build on her/his skills. This is done by clarifying, listening, accepting and interpreting what the mentee does and says. The mentee benefits by being open with the mentor and the mentee's self-confidence increases. From new self-knowledge, the mentee re-evaluates her/his own strengths and areas of need. This may change the mentoring goals and objectives. Time must be taken to explore these changes.

Unfortunately, not every helping interaction will have such positive outcomes as described here. The cultivating phase can sometimes be a difficult phase for both the mentor and mentee.

The mentee may be disappointed initially when expecting too much of her/himself. S/he may also experience feelings of uncertainty, anxiety and failure when gaining new insight as self-examination is done. At times s/he may be so anxious that s/he may withdraw for a period of time and avoid working on self-discovery. A mentor must help a mentee to have realistic objectives and goals.

The mentor may live through different experiences also. The mentor may leave her/his facilitative, reflective, mentoring role and function more as a health care provider. The mentor must be careful not to over-use the observer role and not interact appropriately and warmly. The mentor must guide the mentor-mentee interaction so that the mentee will benefit the most.

As the mentor understands the mentee's level of knowledge and skills, s/he might begin to see common aspects between the two. As the mentee experiences self-discovery, it becomes a two-way learning process for both.

The working and cultivation phase is usually the longest phase of the interaction.

iv) End of relationship phase / resolution

The ideal end of the relationship occurs when the needs or goals of the mentee have been met or there is successful completion of the programme. However, ending the mentor-mentee relationship may occur suddenly when either a mentee or mentor moves or leaves.

During successful resolution of the relationship, the mentee drifts away from being dependent on the mentor. The mentor is pleased with the mentee's progress and excited to see the growth in the mentee's professional role. The mentee's needs are met and s/he can move toward new goals. As a result of this process, both of them become stronger maturing individuals.

To plan for a successful resolution to the relationship, several things may be helpful:

- Be clear from the beginning about how long the mentoring relationship will last.
- Plan a specific time/meeting to discuss the end of the mentoring relationship. At this time the mentor and mentee can:
    - Assess the mentoring.
    - Review what happened and how mutual goals and objectives were met.
    - Discuss how they both feel about the end of the interaction and express appreciation for what each had given and received in the relationship.
    - Discuss the mentee's plans / next steps for the future. The mentee may now need a different mentor or may want to become a mentor.
    - Celebrate the accomplishment.

v) Re-definition phase

When mentoring is completed, the mentor and mentee need to re-define their relationship. The relationship may continue formally or informally. Team building is often a positive outcome of the mentoring relationship and process.

Session 3.2 Communication Skills

Session Objectives:

At the end of this session, you should be able to:

- Identify potential barriers to relationship-building
- Identify the basic principles of feedback
- Explain the important role of feedback in the context of clinical mentoring
- Demonstrate effective communication styles and constructive feedback

Session Instructions:

Listen to the presentation on communication skills and follow the facilitator's instructions.

Overview

Communication is one of the most important contributors to normal human relationships. Even in training, effective communication takes centre stage. You need to employ good communication strategies in order to create a successful teaching and learning atmosphere. Learning effective communication skills is important for building relationships. Establishing rapport is the first phase of effective communication which includes greeting, welcoming, showing that you care and have time for the mentee.

Types of Communication

Communication is both verbal and non-verbal; only seven to 11% of all communication is verbal, and the rest is nonverbal. Nonverbal communication may not always match a verbal message. Differences in how messages are perceived can lead to confusion.

We often communicate without words. For example:

- Drumming
- Storytelling
- Drama
- Visual images
- Written and spoken language
- Hand signals

Sometimes people use nonverbal communication signs instead of expressing themselves verbally because they may feel uncomfortable expressing emotions such as anger, boredom or confusion verbally.

What do each of these body language presentations mean?

This relates to the mentor-mentee relationship in that the clinical mentor needs to be aware both of what the health care worker might be communicating nonverbally to her/him, and what s/he as a mentor is communicating nonverbally to the health care worker (HCW).

Barriers to Communication

Communication can be hindered by a number of things. These include:

- Age differences
- Gender differences
- Levels of education
- Cultural differences
- Religious differences
- Social differences
- Varying attitudes

Other barriers to communicating include:

- Looking out the window
- Looking at the clock or watch
- Starting to speak to someone else
- Shuffling papers

If barriers to communication are not addressed, negative consequences may follow, such as:

- Information not shared or understood
- A client may ask few questions despite having many issues that need addressing
- Problems may not be solved
- Adherence to medical appointments and/or treatment may be hindered

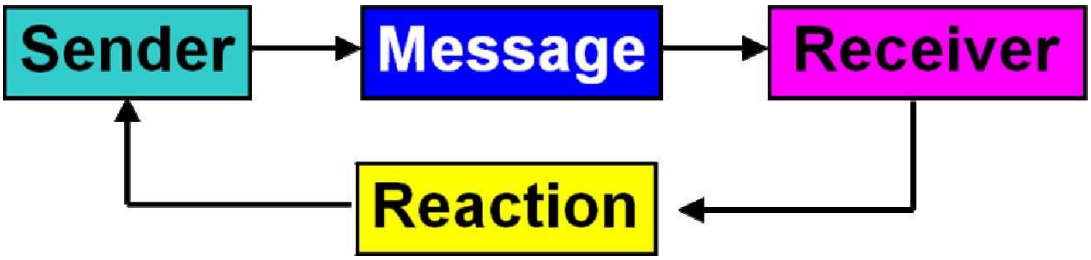
Note that the example above depicts a health care worker with a patient, not a mentor and mentee. However, the same barriers to communication could exist between a mentor and mentee. Alternatively, this is a scene that a mentor might observe in the clinic and give feedback to a mentee about.

These barriers to communication are avoidable. However, once barriers to communication have surfaced, a significant amount of work may be necessary to overcome them.

Communication Process:

Effective communication means that the correct message goes from the sender to the receiver successfully, in the way the sender intended. Just because a message is sent does not mean that it was received accurately. Effective communication requires the ability of both the sender and the receiver (mentee and mentor in the clinical mentoring context) to:

- Listen carefully
- Pay attention and try to understand the other person's concerns and needs
- Ask questions
- Perceive what the other is trying to communicate
- Respond verbally or nonverbally; i.e., react
- Demonstrate a caring attitude, and help to solve problems.



Types of effective communication include:

- Active listening
- Reflecting
- Summarizing

Active listening

Beyond your observations, you must be actively listening. This means paying attention to the patient, health care worker, pharmacist, counselor, nurse, data entry person. Mentors must listen without judgment.

Listening is one of the most important skills you can have. How well you listen has a major impact on your job effectiveness and on the quality of your relationships with others.

By becoming a better listener, you will improve your productivity, as well as your ability to influence, persuade and negotiate. What's more, you'll avoid conflict and misunderstandings. All of these are necessary for mentorship success!

The way to become a better listener is to practice "active listening". This is where you make a conscious effort to hear not only the words that another person is saying but, more importantly, try to understand the complete message being sent.

In order to do this you must pay attention to the other person very carefully.

You cannot allow yourself to become distracted by whatever else may be going on around you, or by forming counter arguments that you'll make when the other person stops speaking. Nor can you allow yourself to get bored and lose focus on what the other person is saying.

To enhance your listening skills, you need to let the other person know that you are listening to what he or she is saying. To understand the importance of this, ask yourself if you've ever been engaged in a conversation when you wondered if the other person was listening to what you were saying. You wonder

if your message is getting across, or if it's even worthwhile continuing to speak. It feels like talking to a brick wall, and it's something you want to avoid.

There are six key elements of active listening. They all help you ensure that you hear the other person, and that the other person knows you are hearing what they say.

1.Pay attention

Give the speaker your undivided attention and acknowledge the message. Recognise that non-verbal communication also "speaks" loudly.

1. Look at the speaker directly (make eye contact).
2. Put aside distracting thoughts. Don't mentally prepare an immediate response!
3. Avoid being distracted by environmental factors.
4. "Listen" to the speaker's body language.
5. Refrain from side conversations when listening in a group setting.

2.Show that you are listening

Use your own body language and gestures to convey your attention.

- Nod occasionally.
- Smile and use other facial expressions.
- Note your posture and make sure it is open and inviting.
- Encourage the speaker to continue with small verbal comments like “yes” and “uh huh”.

3.Clarify, reflect and summarize

Our personal filters, assumptions, judgments, and beliefs can distort what we hear. As a listener, your role is to understand what is being said. This may require you to reflect what is being said and ask questions.

- **Reflect** what has been said by paraphrasing. "What I'm hearing is" and "Sounds like you are saying" are great ways to reflect back.
- Ask questions to **clarify** certain points. "What do you mean when you say" "Is this what you mean?"
- **Summarize** the speaker's comments periodically.

The question of “why” is integral to good mentoring: Open-ended questions are useful for learning the mentee’s motivation. Open-ended questions are questions that cannot be answered with a single word, and therefore encourage meaningful answers. Open-ended questions often begin with “Tell me,” “Why,” or “How.” Compare the following ways of asking the same thing: “You didn’t think cotrimoxazole prophylaxis was indicated for this patient?” “Tell me more about your decision not to start cotrimoxazole prophylaxis with this patient.”

Tip: If you find yourself responding emotionally to what someone said, say so, and ask for more information: "I may not be understanding you correctly, and I find myself taking what you said personally. What I thought you just said is …; is that what you meant?”

4. Provide feedback

Giving feedback constructively improves learning. It can also improve competence. This feedback may be given as an evaluation of the health care worker or at any other time when commenting on their work and performance.

Constructive feedback: It is important that as well as being positive in tone (for reasons of building elf-esteem, morale and the development of good communication skills), there should be discussion on areas for improvement –but this feedback should be positive in content. You should aim to give feedback about

both deficiencies and strengths. People won't get great at their jobs unless you do a great job of giving them feedback.

Note that feedback can be positive or critical, but the sole purpose is to improve performance and not punish poor performance. How we give feedback—what we say, how we say it, when we say it—is critical to whether the feedback is effective and achieves the intended effect.

Basic Principles of Giving Feedback

- Ask permission or identify that you are giving feedback. Examples:
    - "Can I give you some feedback on that follow-up patient visit?"
    - "I'd like to provide some feedback on what I observed during my visit today."
- Start with a positive observation ("It was good that you…").
- Provide a constructive critical observation or suggestion for improvement.
- Finish with a second positive observation or summary statement.
- Use the first person: "I think," "I saw," "I noticed."
- Describe what you observed and be specific. State facts, not opinions.
- Feedback should address what a person did, not your interpretation of her or his motivation or reason for it.
    - Action: "You skipped several sections of the counselling script."
    - Interpretation: "You skipped several sections of the counselling script. I know you want to finish because it's almost lunch time, but…"
- Don't exaggerate. Avoid terms such as "you always" or "you never."
- Don't be judgmental or use labels. Avoid words like "lazy," "careless," or "forgetful."
- When making suggestions for improvement, use statements like, "You may want to consider…" or "Another option is…"
- You can provide feedback any time: during the clinic visit, immediately afterwards or after you leave the clinic premises.
- Don't wait too long to give feedback. The closer the feedback is to the actual event, the more likely the health care worker will remember the teaching point.
- Certain feedback requires more immediate timing:
    - Example: If you see that the health care worker is doing something in error or omitting a very important step during the visit.
- If you provide feedback during a patient encounter:
    - Do not alarm the health care worker or patient. Put them both at ease.
    - Be very calm and patient as you explain your recommendation.
- Defer judgment
    - Interrupting is a waste of time. It frustrates the speaker and limits full understanding of the message.
- Respond appropriately

- Active listening is a model for respect and understanding. You are gaining information and perspective. You add nothing by attacking the speaker or otherwise putting him or her down.
    - Be candid, open, and honest in your response.
    - Assert your opinions respectfully.
    - Treat the other person as he or she would want to be treated.

Role play on active listening

Follow instructions from your facilitator to conduct role plays using the topics listed below.

Topics:

- Describe what makes a good friend.
- Describe an accomplishment you are proud of.
- Talk about your earliest memories.
- Describe the best vacation you have ever taken.
- Talk about a scary experience you have had that turned out well.
- Talk about someone you admire and why.
- Describe a childhood experience that you remember fondly.
- If you had a day to do anything you wanted, describe what you would do.

Provider Initiated Testing and Counselling Scenario

Instructions:

The scenario below is related to provider-initiated testing and counselling (PITC). Consider the two possible approaches to feedback that follow the scenario.

You are a clinical mentor observing a nurse during pretest counselling of a patient. During the risk assessment, the patient reports that she has a husband and two other sexual partners. She does not use condoms with her husband, but uses condoms with one of her other two partners.

The nurse asks about the three partners in a judgmental tone that results in the patient looking visibly uncomfortable in the room.

How should the clinical mentor provide feedback to the nurse after the visit?

Feedback approach #1:

Clinical mentor (with serious facial expression and harsh tone): "Did you realize that you asked about the three partners in a very judgmental way? Did you see how the patient reacted to your questions? It seems that you must have some personal issues related to sex outside of marriage! I'm worried that this patient will be afraid to return to the clinic in the future! This is not how we expect pretest counselling to be carried out… you need to do this better!"

Feedback approach #2:

Clinical mentor should use supportive nonverbal body language—a kind expression and tone of voice, etc.

"I just wanted to take a couple of minutes to talk about the last client. I really appreciate the way you engaged with the patient like you did. It was excellent that you asked about the number of partners the patient had and about condom use. A suggestion for next time would be to probe further about the condom use. For example, once the patient reported that she didn't use condoms with her husband but

uses them with one of her other partners, you could specifically ask which partner she uses condoms with—number one, number two, or number three? Ask if she uses condoms sometimes or always with that partner. Ask why she does not use condoms with number one and number two. Ask her if she thinks that she is at risk for HIV when she does not use condoms.

"It's also extremely important to counsel patients in a manner that doesn't make the patient uncomfortable with you. If the patient starts to feel uneasy during the visit—like you might be judging them in some way—it's very likely that she will not disclose information regarding her HIV risk in an honest manner. So even though you may not personally agree with someone's behaviour, our role in counselling is to give the client enough information to show the client how best to keep a low risk profile for acquiring HIV. But ultimately, the patient must make the decision about what behaviour she chooses to adopt.

"Do you have questions about what I've just talked about? How do you think you can practice being impartial to client's responses about their behaviour in the future?"

Discussion questions:

- What were some differences between these two scenarios?
- What did the health care worker likely learn in the first feedback approach?
- What did the health care worker likely learn in the second feedback approach?

Feedback Scenarios

Instructions:

Listen to the facilitator's instructions for this exercise.

Scenario 1

The clinical mentor observed a PITC pretest counselling visit and noticed the following about the health care worker she followed:

- The health care worker displayed effective interpersonal skills with the patient.
- The health care worker did not reassure the patient of the confidentiality between the client and the
- Health care worker.
- The health care worker did not document the counselling properly in the patient record.
- The health care worker was good about encouraging the patient to return to the clinic for follow-up
- HIV testing in three to six months if her results end up being negative this visit.

Scenario 2

The clinical mentor observed a PITC post-test counselling visit for an HIV-infected patient and noticed the following about the health care worker he followed:

- The health care worker did not give the client sufficient time to absorb the news about the HIV diagnosis; instead, he immediately started talking about safe sex practices and the need for 100% condom use.
- At the end of the visit, the health care worker told the client about services available for HIV patients, CD4 counts, clinical management and follow-up, available support groups, social welfare support, etc.
- The health care worker did not cross check the client's health passport, register and lab printout to make sure that the client ID number was consistent for all three.

Scenario 3

The clinical mentor observed an antenatal care (ANC) visit and noticed the following about the health care worker she followed:

- The health care worker forgot to enquire whether this patient had young children at home who might need HIV testing or to enquire whether her partner had been tested yet.
- The health care worker included a thorough explanation of the benefits of PMTCT programmes for HIV positive women.
- The HCW told the patient that she should avoid breast feeding and use Lactogen infant formula to feed her baby.

Scenario 4

The clinical mentor observed the labour and delivery (L&D) ward and noticed the following about the health care worker she followed:

- The HCW did not use gloves with every client; he would use gloves only for patients whom he thought were HIV positive.
- The midwife indicated that she wanted to perform an episiotomy. She routinely performs an episiotomy for every primigravida that presents to labour and delivery.
- The health care worker reported to give nevirapene (NVP) to the mother and baby at the time of delivery, however failed to note this in the patient record.
- Immediately following the delivery, the health care worker helped guide the mother on how to prepare infant formula feeds for her baby since the mother had decided to formula feed prior to her delivery.

Scenario 5

The clinical mentor observed a follow-up visit at the antiretroviral therapy (ART) clinic. The patient had been on antiretroviral drugs (ARVs) for two months.

- The health care worker asked whether the patient was taking his medications correctly, and the patient responded “yes.” The health care worker didn’t ask the patient about when and how he was taking his medications.
- The health care worker asked helpful follow-up questions about the patient’s reported headache and numbness/tingling in his feet.
- The health care worker did not conduct a neurological examination of the patient.
- The health care worker made an appropriate referral to the physician to follow up on the patient’s symptoms.

Session 3.3: Practicing Affirming Statements

Session Objective:

At the end of this session, you should be able to:

- Employ affirmative approaches in communication

Overview

Using affirming statements is one technique used to help build rapport. Affirmation encourages mentees to build upon their successes. Modeling affirming statements will both encourage further success among mentees, as well as the model behaviour that health care workers can (and should) use with their patients. Directly affirming and supporting the mentee during the mentoring process is an important way of building rapport and reinforcing your relationship, as well as encouraging exploration. Compliments or statements of appreciation and understanding are examples of affirming statements.

Affirmations will differ by culture and setting. The point is to appropriately and consistently appreciate the mentee's strengths and efforts. Note how these statements can be used to build mentees' self-confidence. The accomplishments do not have to be grand accomplishments, but rather can be small positive gains or even efforts that were not completely successful.

Exercise 1: Affirming Statements Instructions:

1. *Use the space provided below to write down three to four positive accomplishments or efforts you have made as a health care worker in patient care.*
2. *Pair up with the person next to you. Read each of your accomplishments and allow your partner to respond with an affirming statement. Switch roles so each partner has the chance to read their accomplishments and provide affirming statements.*
3. *Follow instructions from the facilitator to debrief this activity.*

Positive accomplishments

1.

2.

3.

4.

Exercise 2: Examining Cultural Differences Instructions:

1. *Fill out the chart below for yourself as the mentor. Then fill out the mentee column based on what you generally know about the people you will be mentoring.*
2. *Form groups to discuss your charts and consider the questions below the chart. You will debrief responses to these questions and this activity in a large group once you are finished.*

Examining cultural differences

	You, the mentor		**Your mentee(s)**
Gender			
Race/ ethnicity			
National/ regional origin			
Language			
Age			
Profession			
Level of education			
Religion			
Other: health issues, etc.			

1. How might the differences between your column and the mentee column affect your mentee's attitude?
    a. Upon meeting you?
    b. As you begin interacting with her/him?
    c. As you begin providing feedback about her/his performance?
2. How might these differences affect your attitude?
    a. Before meeting your mentee?
    b. Upon meeting her/him?
    c. As you start building a relationship with her/him?
3. When confronted with situations that are not immediately comfortable, what are some steps you, as a mentor can take in order to overcome the discomfort/mistrust?
4. If your columns are more similar than different, what implications might that have for your mentor/mentee relationship?

Session 3.4 Conflict Management

Session objectives:

At the end of this session, you should be able to:

- Define conflict and state causes of conflict
- Describe the ways by which conflict can be managed

Overview

It is important to note that managing conflict is an important ingredient to managing relationships. There are times when a mentor may not recognise the existence of a conflict in the course of interaction with mentees or learners. However, when you are able to perceive or recognise a conflict, ensure that it is quickly managed in order to revert to a conducive learning environment.

Conflicts are often inevitable. Getting the most out of diversity often means that contradictory values, perspectives and opinion will be expressed. Conflict is not always detrimental but can be good. For example, good teams usually go through a "form, storm, norm and perform" period.

This module provides steps on how to identify that conflict exists and how to resolve them.

Definitions and Causes of Conflict

There are various definitions of conflict. In this manual, we adopt the following definition:

Conflict is when two or more values, perspectives and opinions are contradictory in nature and haven't been aligned or agreed about yet; these can be internal (within yourself when you're not acting or living in concordance with your personal values) or external when your values and perspectives are threatened.

Occasionally, conflicts emanate from more than one source, and so their true origin may be hard to identify. Important initiators of conflict situations include:

1. **Disagreement between two or more people:** People disagree for a number of reasons. They see things differently because of differences in understanding and varying viewpoints or perceptions. A classic example of varying viewpoints is the case of the half-full glass of one individual which can be half-empty to another. Most of these differences are usually not important. Personality differences or clashes in emotional needs may cause conflicts. These may include:
    - Contradicting choices: People have different styles, principles, values, beliefs and slogans which determine their choices and objectives. When choices contradict, people want different things and that can create conflict situations. For example, a risk-taking manager would be in conflict with a risk-minimizing supervisor who believes in firm control and a well-kept routine.
    - Different ideological and philosophical outlooks: People have different ideological and philosophical outlooks, as in the case of different political parties. Their concepts, objectives and ways of reacting to various situations are different. This often creates conflicts among them.
2. **Differences in status**: Conflict situations can arise because people have different status. When people at higher levels in the organization feel indignant about suggestions for change put forward from their subordinates or associates or vice versa, it provokes conflict. By tolerating and allowing such suggestions, potential conflict can be prevented.

3. **Different thinking styles**: People have different thinking styles, which encourage them to disagree, leading to conflict situations. Certain thinking styles may be useful for certain purposes, but ineffectual or even perilous in other situations.
4. **Varying moral values and sense of fairness**: fairness refers to an individual's sense of what is right and what is not right, a fundamental factor learnt in early childhood. This sense of fairness determines the moral values of an individual. People have different moral values and accordingly appreciate a situation in different ways, creating conflict situations.

Other conditions creating conflict, particularly in the workplace are:

- ***Ambiguous jurisdiction,*** which occurs when two individuals have responsibilities which are interdependent but whose work boundaries and role definitions are not clearly specified.
- ***Goal incompatibility and conflict of interest*** refers to accomplishment of different but mutually conflicting goals by two individuals working together in an organization. Obstructions in accomplishing goals and lack of clarity on how to do a job may initiate conflicts. Barriers to goal accomplishment arise when goal attainment by an individual or group is seen as preventing another party achieving their goal.
- ***Communication barriers;*** difficulties in communicating can cause misunderstanding, which can then create conflict situations.
- ***Dependence on one party*** by another group or individual.
- ***Unresolved prior conflicts*** which remain unsettled over time create anxiety and stress, which can further intensify existing conflicts. A manager's most important function is to avoid potential harmful results of conflict by regulating and directing it into areas beneficial for the organization.

Ways of Managing Conflict

Conflict may be managed through a logical process. The model below may be used in managing conflict.

Though conflict management and conflict resolution are often used interchangeably, they can be considered to be distinct from each other. Conflict management refers to the long-term management of conflicts; the conflict is handled but may still exist. Conflict resolution is a range of methods of eliminating sources of conflict or can be considered as a process of working through opposing views in order to reach a common goal or mutual purpose; an agreement is reached so that the conflict no longer exists or is solved. Processes of conflict resolution generally include **negotiation, mediation**, and **diplomacy**.

Response Styles

Since people appreciate or perceive situations differently, they may therefore respond in varying ways. It is therefore necessary to understand the response styles of the people involved so as to manage conflicts properly. According to Turner and Weed (1983), responses can be classified as follows:

- *Addressers* are the people who are willing to take initiatives and risks to resolve conflicts by getting their opponents to agree with them on some issues. Addressers can either be first-steppers or confronters:
    - *First-steppers* are those who believe that some trust has to be established to settle conflicts. They offer to make a gesture of affability, agreeableness or sympathy with the other person's views in exchange for a similar response.
    - *Confronters* think that things are so bad that they have nothing to lose by a confrontation. They might be confronting because they have authority and a safe position, which reduces their vulnerability to any loss.

- Concealers take no risk and so say nothing. They conceal their views and feelings. Concealers can be of three kinds:
    - *Feeling-swallowers* swallow their feelings. They smile even if the situation is causing them pain and distress. They behave thus because they consider the approval of other people important and feel that it would be dangerous to affront them by revealing their true feelings.
    - *Subject-changers* find the real issue too difficult to handle. They change the topic by finding something on which there can be some agreement with the conflicting party. This response style usually does not solve the problem. Instead, it can create problems for the people who use this and for the organization in which such people are working.
    - *Avoiders* often go out of their way to avoid conflicts.
- *Attackers* cannot keep their feelings to themselves. They are angry for one or another reason, even though it may not be anyone's fault. They express their feelings by attacking whatever they can eventhough that may not be the cause of their distress. Attackers may be up-front or behind-the-back:
    - *Up-front attackers* are the angry people who attack openly; they make work more pleasant for the person who is the target, since their attack usually generates sympathy, support and agreement for the target.
    - *Behind-the-back attackers* are difficult to handle because the target person is not sure of the source of any criticism, nor even always sure that there is criticism.

Ways to Address Conflict

Conflict management strategies should aim at keeping conflict at a level at which different ideas and viewpoints are fully voiced but unproductive conflicts are deterred. Conflict should be managed effectively rather than avoided or suppressed.

Five basic ways of addressing conflict

- ***Accommodation*** – surrender one's own needs and wishes to accommodate the other party.
- ***Avoidance*** – avoid or postpone conflict by ignoring it, changing the subject, etc. Avoidance can be useful as a temporary measure to buy time or as an expedient means of dealing with very minor, non-recurring conflicts. In more severe cases, conflict avoidance can involve severing a relationship or leaving a group.
- ***Collaboration*** – work together to find a mutually beneficial solution. Collaboration can be viewed as the only win-win solution to conflict, however it can be time-intensive and inappropriate when there is not enough trust, respect or communication among participants for collaboration to occur.
- ***Compromise*** – bring the problem into the open and have the third person present. The aim of conflict resolution is to reach agreement and most often this will mean compromise.
- ***Competition*** – assert one's viewpoint at the potential expense of another. It can be useful when achieving one's objectives outweighs one's concern for the relationship.

Tips for Conflict Management

- Isolate the facts from the emotions; it is important to acknowledge feelings but base decisions on facts
- Listen more
- Try to empathize with the other party
- Avoid being defensive
- Be willing to change you perception and respect other people’s perspectives

- Build good relationships before conflicts arise
- Do not let small problems grow bigger – nip them in the bud
- Adapt to each particular situation
- External mediators may be needed for certain situations

Module Summary

1. Relationships are the foundation of effective clinical mentoring.
    - Strategies to build rapport include active listening, patience, eye contact, use of affirming statements and respect.
2. Good communiation (both verbal and non-verbal) is essential for an effective mentoring process.
3. Communication techniques such as appropriate body language, active, reflective listening and understanding can aid communication.
4. Feedback is vital to adult learning and is a vital component of the clinical mentoring relationship.
5. Feedback should include both positive and "how to improve" commentary; be descriptive, objective and non-judgemental. Focus on the individual's actions.
6. While knowledge about a subject is a pre-requisite for effective teaching, learning is more often about how knowledge is communicated.
7. Barriers to building relationships can hinder effective communication.
8. There can be barriers to building mentorship relationships based on cultural differences, expectations, attitudes, gender, age and differences in level of knowledge. Mentors can come prepared with strategies to overcome these barriers.
9. Conflict is when two or more values, perspectives and opinions are contradictory.
10. Differences in understanding, choices, status, ideologies, thinking styles, and moral values between a mentor and a mentee can create conflict in a mentorship process.
11. Conflict should be managed effectively rather than avoided or suppressed.

Module 4.0: General Principles of Critical Thinking

 **Duration: 1 hour 45 minutes**

Module Objective:

At the end of this module, you should be able to:

- Describe and follow a scientific approach in problem solving

Session Plan for Module 4

Time	Session	Facilitation and active learning strategies
15 minutes	Scientific models of thinking	Presentation Interactive question and answer
15 minutes	Clinical thinking and reasoning	Presentation Interactive question and answer
1 hour 15 minutes	The problem solving approach	Presentation Interactive question and answer Problem solving approach case simulation Group presentations

Introduction

To learn a subject well, learners must master the thinking that defines that subject. Similarly, instructors must design activities and assignments that require students to think actively within the concepts and principles of the subject. As a trainee mentor you must master fundamental concepts and principles before attempting to learn more advanced concepts.

The purpose of this module therefore, is to give you information that will be critical in your daily interaction with mentees, colleagues and patients in a logical manner. It also sets the foundation for your clinical reasoning skills.

Session 4.1 Scientific Models of Thinking

Session Objective:

At the end of this session, you should able to:

- Employ a scientific approach in problem solving

Overview

Critical thinking can occur whenever one judges, decides, or solves a problem, in general, whenever one must figure out what to believe or what to do, and do so in a reasonable and reflective way. Reading, writing, speaking, and listening can all be done critically or uncritically. Critical thinking is crucial to becoming a close reader and a substantive writer. Expressed most generally, critical thinking is "a way of taking up the problems of life."

The Scientific Basis of Critical Thinking

In a narrow sense, critical thinking has been described as "the correct assessing of statements and situations." It has also been described popularly and narrowly as "thinking about thinking."

It has been described in a much more comprehensive sense as "the intellectually disciplined process of actively and skillfully conceptualising, applying, analysing, synthesising, and/or evaluating information gathered from, or generated by observation, experience, reflection, reasoning, or communication, as a guide to belief and action".

How does the scientific attitude encourage critical thinking?

The scientific attitude reflects a hard-headed curiosity to explore and understand the world without being fooled by it. This attitude, coupled with scientific principles for sifting reality from illusion, helps us separate sense from nonsense. In critical thinking, we tend to: ***examine assumptions, discern hidden values, evaluate evidence, and assess conclusions.***

The scientific model of critical thinking tends to employ a wide range of observations and testable predictions, called hypotheses. As a health scientist or practitioner, you should gather complete information; that is, gathering all available facts on a subject under scrutiny. Erroneous conclusions often stem from inadequate factual knowledge.

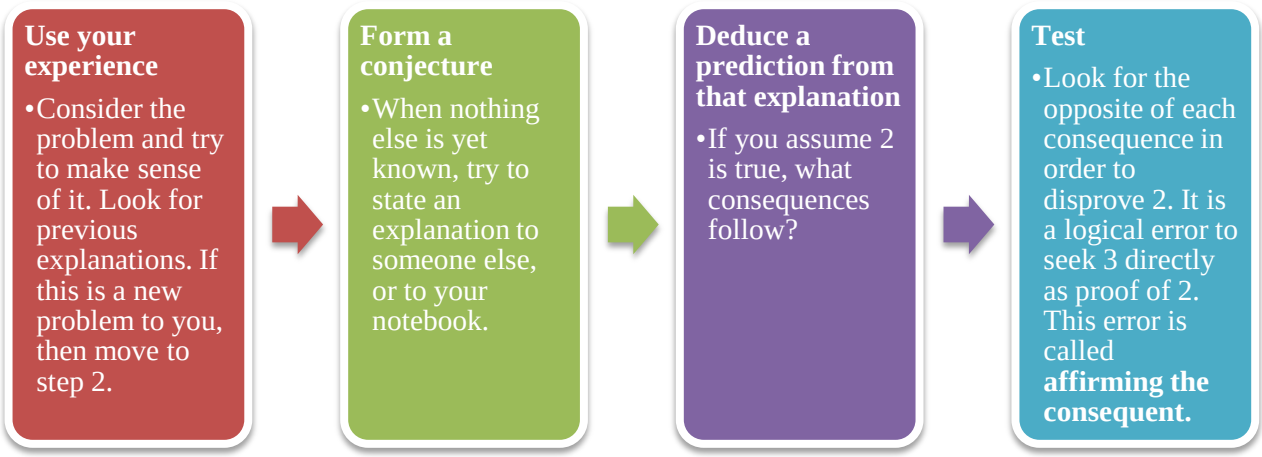
The steps listed below should be followed whenever faced with a problem that needs solving:

1. Gather complete information
2. Understand and define all terms
3. Question the methods by which the facts are derived
4. Question the conclusions
5. Look for hidden assumptions and biases
6. Question the source of facts
7. Don't expect all of the answers
8. Examine the big picture
9. Examine multiple cause and effect

10. Watch for thought stoppers
11. Understand your own biases and values

Remember that this is only a guide to critical thinking. The steps may not always be applied in the order shown above. However, it is prudent to use a logical approach and to conduct issue analysis for every problem.

Another model of critical thinking may be as follows:



Session 4.2 Clinical Thinking and Reasoning

Session Objectives:

By the end of this session, you should be able to:

- Explain the importance of critical thinking and reasoning
- Identify common errors in clinical reasoning that should be avoided

Overview

Critical thinking is deciding the meaning and significance of what is observed or expressed and if there is adequate justification to accept the conclusion as true. Critical thinking can occur whenever one judges, decides, or solves a problem in a reasonable and reflective way. Critical thinking uses not only **logic** but broad **intellectual** skills such as clarity, credibility, accuracy, relevance, significance and fairness.

REMEMBER

Within an educational programme, it is impossible to teach everything.

If critical thinking is taught and used rather than rote memorization, a person is equipped for life-long learning.

Evidence-Based Medicine

Because mentors are placed in resource-limited settings, some of the diagnostic technologies and tests that are normally used to produce evidence of a disease may be lacking. Therefore developing clinical reasoning and diagnostic skills using a patient's history and physical examination are crucial.

Principles of Evidence-Based Medicine

Nine principles of evidence-based medicine guide the clinician in diagnosis. The nine principles emphasise the most common causes of errors in clinical reasoning. They also indicate potentially fatal causes of errors in clinical reasoning. *These nine principles are:*

Principle 1: Occam 's razor

- Advises choosing the simplest hypothesis to explain a set of clinical findings.
- The caveat is that in immune-compromised patients, more than one pathological process may be at work.

Principle 2: Sutton's Law

- Considers local common causes for a set of symptoms before considering uncommon causes.

Principle 3:

- In contrast to Sutton's Law, considers conditions that might kill a patient quickly, even if they are uncommon.
- When planning treatment, covers the most common causes and the most serious (life-threatening) possible causes.

Principle 4:

- Avoids premature closure of the diagnostic process; starts with a broad differential diagnosis and does not eliminate possibilities without sufficient evidence.

Principle 5:

- Isn't overconfident about your differential diagnoses—asks questions to disprove as well as confirm the hypothesised diagnoses.

Principle 6:

- Know what you don't know and seek out help from a book, a consultant, or the Internet.

Principle 7:

- Common diseases often have uncommon presentations, and uncommon diseases can look like very common ones. Just because a clinical presentation looks similar to Illness X does not mean that Illness X is the cause.

Principle 8:

- Correlation is not equivalent to causation. Just because two findings occur together does not mean that one caused the other.

Principle 9:

- Remember that it is common to over-diagnose conditions that we have recently seen, especially ones that are dramatic.

Session 4.3 Problem Solving Approach

Session Objective:

At the end of this session, you should be able to:

- Follow a logical approach to problem solving

Overview

The problem solving approach is used to identify the normal and the abnormal, to make decisions about problems and needs, and to give lifesaving care to patients. This method guides you to gather information which leads to safe and effective care. The problem solving approach should be used in a manner that is polite, respectful, and supportive.

When a patient comes to you, you should try to learn all you can about her/his problems and needs. The problem solving approach steps are provided below.

Problem Solving Approach Steps

The 5 steps of the problem solving approach are:

ASK and LISTEN (History)	Take a history
LOOK and FEEL (Physical Examination)	Do a physical examination
IDENTIFY PROBLEMS / NEEDS (Diagnosis)	Decide problems and needs
DO A PLAN OF CARE	Make a plan of care with the patient and family Do laboratory tests to gather more information Give treatment for the problem / to address needs Provide education, information, advice Give counselling to help understanding Refer as necessary for more care Plan for follow-up to evaluate the care Record all actions
FOLLOW-UP/ EVALUATE / REPEAT PROCESS	Discuss with the patient/family the results of the care Repeat the first 4 steps

REMEMBER

When you first see a patient who says s/he is not well or the family says s/he is not well, quickly decide how serious the problem is. This may be a life threatening problem. If it is a life-threatening condition, give the patient emergency treatment. After you have treated the patient continue the problem solving approach.

1. **ASK and LISTEN (History)**

This is the first step that is done when a patient/caregiver comes to you for care. Make them feel welcome. Go to a private area to talk. Ask questions in a kind and interested way. Ask about the reason they came to see you. Listen carefully to all the answers. All answers are important and will help you

find the problems. Help her/him feel comfortable with your actions. Write down the important points so you will not forget the answers. Recognise the need for immediate emergency care.

Ask Questions to Help Understand the Problem Better

- ***Start of the problem:*** When did it start? Did it start gradually or suddenly? Did anything unusual happen before it started? Did anything cause it to happen?
- ***What s/he is feeling:*** Where does s/he feel or have the problem? Is it constant or does it come and go? What does it feel like? Is it feeling better, worse or staying the same?
- ***Help to solve the problem:*** Has s/he or anyone done anything for the problem? What was done? Did it help the problem?

2. LOOK and FEEL (Physical Examination)

This is the second step that is done when seeing a patient. Do a general examination first. Then do a targeted examination focusing on the areas of the body with the complaint, concern or problem. Recognise the need for immediate emergency care.

When seeing a patient for routine care, follow the appropriate checklist. Sometimes you may need to do a systemic review. For example, you may not be able to find the cause of the complaint from what you have been told. You may need to ask more questions and do more examination. A general examination of the patient may help you find problems that the patient/caregiver has not recognised.

3. IDENTIFY PROBLEMS/ADDRESS NEEDS

This is the third step of the problem solving approach. Use information from the ASK and LISTEN and the LOOK and FEEL steps and your knowledge and experience to compare information and identify the problems and needs.

If you do not find a problem, review everything with the patient and the family to make sure you did not miss something. If nothing is found, reassure the patient and family and encourage them to return if the problem persists or worsens. If the patient does not appear to be well or you are just worried, refer to the senior colleague/doctor or hospital. If you identify a problem or need and do not have the medicine or know how to help, refer to a senior colleague/ doctor or hospital. A patient may come with only one complaint, problem, or question. However, as you talk with her/him or the caregiver, you find s/he has many needs such as needing nutrition advice or where to go for immunizations for small children. Try to help with all problems or needs.

Note: It is common for mentees' first learning to make only one assessment. It is important for a mentor to encourage mentees to think about all the problems and needs the client has.

4. DO A PLAN OF CARE

This is the fourth step. You must give care. Decide what should be done to solve each problem or meet each need. The following actions should be considered, and you must decide which to do first, second, and so on. Sometimes in case of a life-threatening event, treatment will be needed first before investigations are done.

Treatment: Take care of the problem with medicine(s) or other treatment, following appropriate standards and protocols of practice.

Education: Help the patient/caregiver learn the information they must know in order to care for themselves or the patient.

Counselling: Have a conversation with the patient and her family. Listen, help and teach them to make decisions about the needed health care. Help them understand the problem or needs. Find out if the patient/caregiver can do what you advise. Help them decide how to do what you are advising and work

with the family so they can also help the patient. Give them time to ask questions, talk about what has been discussed, and listen to their concerns. It is important that the patient and family or caregiver to understand what they need to do and how to do the care when they get home. Ask the patient/caregiver to repeat important information or instructions to be sure they understand.

Laboratory tests / investigations: Laboratory tests and other investigations will help get more information about the problem to confirm your findings.

Referrals: When necessary, use other resources in the area, such as doctors, hospitals, education programmes, women's groups, or charity groups to help the patient solve her/his problems.

Plan for follow-up: Ask the patient/caregiver to return and explain when s/he should return and why.

Recording: Write all information gathered during the history, physical examination, problems and needs identified, and plan of care (medical treatment, education, counselling, laboratory information, referrals, and date to return for care) clearly and carefully in the patient's record.

Note: It is helpful for mentees to consider all the problems the patient has in the plan . This helps make a complete plan so important actions are not missed.

5. Evaluate

This step will help decide if the actions taken were effective at resolving the problem or helping the patient's need. At the next visit, to decide if the problem is solved, staying the same or getting worse, repeat the problem solving approach. You may have to develop a new care plan. The patient/caregiver may need to have information or advice repeated to be sure s/he understands. If the problem does not resolve or is getting worse, refer the patient to a higher level of care or a more senior colleague.

Exercise:

Follow the facilitator's instruction to simulate the problem solving approach on the following cases.

Case 1. Muthanthu is a 25 year old male patient. He lives in Chongwe. He is complaining of diarrhoea, vomiting and fever for three days. He is feeling weak and dizzy. The wife also complains that her husband looks pale and has yellow eyes. She also complains that his skin and tongue are rather dry and appear wrinkled. He has also developed a swelling inside the abdomen on the left side.

Case 2. Ziala is a two year old female child. The mother noticed that Ziala has swelling of both hands and feet and has been crying a lot particularly when the hands and feet are touched. She refuses to walk since the swelling occurred. The mother has also noticed that Ziala has yellow eyes and looks pale. She also has a swelling on the left side of her abdomen.

How mentors can help you do the problem solving process

Problem Solving Step	How Mentors Can Help Mentees
History (ASK and LISTEN)	Coach and supervise mentees. Ensure history taken by mentee is accurate and complete.
Physical Examination (LOOK and FEEL)	Observe to ensure mentee is doing all examinations needed and does the examination correctly. Coach mentee if needed. Confirm all results obtained by mentee during examination of client. If not, correct and guide the mentee.
Diagnosis (PROBLEMS/NEEDS)	Ask mentee to identify cause of problem. Ensure diagnosis is correct. Ensure mentee identifies ALL diagnoses/problems.
PLAN OF CARE	Ask mentee to prepare plan of care. Review before plant is implemented. Ensure there is a complete plan for EACH diagnosis/problem.
EVALUATE PLAN OF CARE	Ask mentee to evaluate previous plan of care during revisits.

Module Summary

- Critical thinking is defined as the correct assessing of statements and situations.
- In critical thinking we exam assumptions, discern hidden values, evaluate evidence and assess conclusions.
- Clinical reasoning and diagnostic skills are useful, particularly in resource limited settings.
- There are principles of evidence-based medicine that guide the clinician in diagnosis.
- The problem solving approach is used to make decisions about problems and needs

Module 5.0: Clinical Teaching Skills

 **Duration: 3 hours 15 minutes**

Module Objective:

At the end of this module you should be able to:

- Employ clinical teaching skills to interact with and mentor mentees successfully.

Session Plan for Module 5

Time	Session	Facilitation and active learning strategies
3 hours 15 minutes	Clinical Teaching Skills	Presentation Interactive question and answer Brainstorming

Session 5.1 Clinical Teaching Skills

Session Objectives:

By the end of this session, you should be able to:

- Define a teaching moment
- Use bedside teaching, side-by-side teaching, and case presentations as teaching strategies

Overview

This session gives you both the information and skills you require to interact with the mentee in a real clinical setting.

Teaching Moments

- Teaching moments may involve
    - Reminding the health care worker about important management principles of specific diseases, e.g., malaria or diabetes mellitus.
    - Reviewing effective history taking and physical examination techniques.
    - Supporting and motivating the health care worker to build her/his confidence.
- Unfortunately, there are times when mentors don't allow staff to take full advantage of their presence in the clinic. One way to identify opportunities for teaching moments is to think of where and when they might occur:
    - Can be done while a patient is in the room.
    - Can be done after a patient visit, e.g., in the hallway while waiting for the next patient, or when you're both on a tea break.
    - Can be planned for in the future, e.g., identify a learning need and schedule a date to give a lecture or a lunchtime informational session.

  Once you've identified a teaching moment and know what you would like to convey to the health care worker, you should think of **how** you will teach.
- As much as possible, teach in ways that engage multiple learning styles at any given time. The more methods you can incorporate into your teaching moments, the more likely it is that you will cover material in a way that the mentee can grasp effectively.
- Mentors should not only be teachers, but should "**talk the talk and walk the walk**"—that is, they should lead by example when interacting with and teaching mentees. The following two slides give specific techniques for teaching mentees effectively.
- **Think aloud:** A mentor should make her/his own clinical reasoning transparent. This might involve:
    - Explaining the thought process that leads to a diagnosis.
    - Verbalizing the treatment options for a challenging case.
    - Explaining why a particular course of action is chosen.
- **Activate the mentee**: Mentors must encourage mentees to be motivated to connect their needs with patients' needs.
- **Listen smart.** An adaptable, collaborative approach to clinical teaching is most effective—

mentors must know when to stand back or jump in, while still giving enough freedom to the mentee to grow without hurting themselves or patients.

- **Keep it simple:** It is important for the mentor to efficiently assess the mentee's acquisition, synthesis, and presentation of clinical data, even if the mentor does not have previous knowledge about the patient.
- **Work as a hands-on role model:**
    - Show the clinical utility of physical examination, the therapeutic value of touching, and the diverse benefits of bedside care.
- **Adapt** to uncertainty with enthusiasm:
    - Uncertainty is always going to be a part of clinical practice. A mentor must be able to change her/his mind, admit mistakes, etc.
- **Link learning to caring:**
    - It is important to practice patient-centreed teaching
- Be **kind**.

Bedside Teaching

The rationale for bedside teaching is that it is a common approach in medical education and reinforces classroom learning. This allows the mentor to model important clinical skills, attitudes, and communication in the context of patient care, as well as to observe the mentee's skills; the strengths and weaknesses of mentees become very clear at the bedside.

While bedside teaching implies an inpatient setting, it can easily be adapted for use in a clinic/outpatient setting. In order to conduct bedside teaching:

- Identify appropriate patients: Appropriate patients will be capable of interacting with the mentor and mentee, or will have family members present that can interact with them (if possible).
    - It is often helpful to arrange a session with the patient ahead of time.
- Set goals: What does the mentee wish to learn or practice?
- Agree on roles and expectations: Who will make introductions? Who will take the lead on each aspect of the visit?
- Timeframe: This is especially important if there is a tight schedule, or the mentor and mentee are seeing multiple patients.

There are five steps to bedside teaching. These are:

1. Get a commitment
2. Probe for supporting evidence
3. Reinforce what was done well
4. Give guidance about errors and omissions
5. Teach a general principle

Step One: Get a Commitment

This pushes the mentee to move beyond her/his level of comfort and makes the teaching encounter more active and more personal. It also shows respect for the learner and fosters an adult learning style. The main goal of getting the learner to commit is to reveal her/his reasoning, not just to get more information about the case.

Questions to ask:

- "What other diagnoses would you consider in this setting?"
- "What investigations should you request?"

- "How do you think we should treat this patient?"
- "Do you think this patient needs to be hospitalized?"
- "Based on the history you obtained, what parts of the physical should we focus on?"

Examples of possible mentor and mentee interaction to get a commitment:

Your question: "Based on this information, what would be your priority tasks to follow-up with this patient today?"

Mentee's reply: "I am mostly concerned that Mary might have a respiratory infection and that I will need to start ART for her today."

Your reply: "Okay, what specific respiratory infections are you worried about at this juncture?"

Mentee's reply: "Mary could potentially have an opportunistic infection [OIs], such as PCP, pulmonary TB or bacterial pneumonia."

Step Two: Probe for Supporting Evidence

It is important to determine that there is an adequate basis for the answer and to encourage an appropriate reasoning process. Instead of giving a right or wrong response to the commitment the learner has made, ask more questions:

- "What factors in the history and physical support your diagnosis?"
- "Why would you choose that particular medication?"
- "Why do you feel this patient should be hospitalized?"
- "Why do you feel it is important to do that part of the physical examination in this situation?"
- "Why have you chosen these investigations?"

Example on probing for supporting evidence:

Your reply: "What elements of your history and physical support these differential diagnoses?"

Mentee: "I am suspicious of PCP pneumonia/TB/bacterial pneumonia because of her history of fever, cough, and progressive shortness of breath, especially given her low CD4 count. Also, she is febrile today and had scattered crackles throughout her lung fields.

Step Three: Reinforce What Was Done Well

This involves the use of positive reinforcement. The simple statement, "That was a good presentation," is not sufficient. Comments should include specific behaviours that demonstrated knowledge, skills, or attitudes valued by the mentor.

- Your diagnosis of "probable pneumonia" was well supported by your history and physical findings. You clearly integrated the patient's history and your physical findings in making that assessment."
- "Your presentation was well-organized. You had the chief complaint followed by a detailed history of present illness. You included appropriate additional medical history and medications and finished with a focused physical exam."

Step Four: Give Guidance about Errors and Omissions

The main idea here is to identify an opportunity for behaviour change and provide an alternative strategy. Instead of using extreme terms such as "bad" or "poor," expressions such as "not best" or "it is preferred" may carry less of a negative value judgment while getting the point across. Comments should also be as specific as possible to the situation, identifying specific behaviours that could be improved upon in the future.

- "In your presentation, you mentioned a temperature in your history but did not tell me the vital signs when you began your physical exam. Following standard patterns in your presentations and

notes will help avoid omissions and will improve your communication of medical information."

- "I agree, at some point, complete pulmonary function testing may be helpful, but right now the patient is acutely ill. The results may not reflect her/his baseline and may be very difficult to interpret. We could get some important information with just a peak flow and pulse oximetry."

Step Five: Teach a General Principle

One of the more challenging but essential tasks of this model is for the learner to take information and accurately generalize it to other situations. The teaching principle does not need to be a medical fact, but can be about strategies or procedures. While there is generally not enough time to have a major teaching session, one or two statements can make a big impact.

- "Deciding whether someone needs to be treated in the hospital for pneumonia is challenging. Fortunately there are some criteria that have been tested which help."
- "In looking for information on what antibiotics to choose for a disease, I have found it more useful to use an up-to-date handbook than a textbook, which may be several years out of date."
- **"**Remember that in general opportunistic infections need to be treated or stabilized before starting HIV patients on ART. This helps to avoid dangerous drug-drug interactions between OI treatment regimens and ART regimens. This also helps to prevent patients from being overwhelmed with taking too many medications at once. Adherence to ART by itself is challenging enough."

Conclusion

Time management in clinical teaching is essential. The conclusion defines the end of the teaching interaction and the role of the learner in the next events.

> "Let's go back in the room and talk with Mary. You can enquire about the history questions I mentioned. And then we can talk about running additional tests to help determine Mary's condition and discuss her treatment options for today. Since she was diagnosed with HIV so recently let's also make sure we spend time answering questions that she may have regarding her condition."

Refer to Table 5.1 for more information on the patient-centreed approach to bedside teaching.

Table 5.1: A Patient-Centred Approach to Bedside Teaching

Step	Task	Purpose	Cue	Action	Do	Don't
1	**Get a commitment**	Gives learner responsibility for patient care. Encourages information processing within learner's database.	Learner presents case, then stops.	Ask what the learner thinks: "What do you think is going on?" "What would you like to do next?"	Do determine how the learner sees the case. (Allows learner to create her/his own formulation of the problem.)	Don't ask for more data about the patient. Don't provide an answer to the problem.
2	**Probe for supporting evidence**	Allows preceptor to diagnose learner.	Learner commits to stance; looks to preceptor for confirmation.	Probe learner's thinking: "What led you to that conclusion?" "What else may be happening here?" "What would you like to do next?"	Do diagnose learner's understanding of the case, i.e., gaps and misconceptions, poor reasoning or attitudes.	Don't ask for textbook knowledge.
	TEACH					
Step	**Task**	**Purpose**	**Cue**	**Action**	**Do**	**Don't**
3	**Choose a single, relevant teaching point**	Focus on specific competencies relevant to this learner working with this patient.	Case decision-making complete or consultation with patient needed.	Provide instruction. The learner (under direction or observation) or preceptor (acting as role model) collects additional information as needed.	Do check for learner agreement with the teaching point.	Don't choose too much to cover.
4	**Teach (or reinforce) a general rule**	Remediate any gaps or mistakes in data, knowledge, or missed connections.	Apparent gaps or mistakes in learner thinking.	Draw or elicit generalizations. "Let's list the key features of this problem." "A way of dealing with this problem is…"	Do help the learner generalize from this case to other cases.	Don't slip into anecdotes, idiosyncratic preferences.
5	**Reinforce what was done right**	Firmly establish and reinforce knowledge.	Teaching point has been delivered.	Provide reinforcement. "Specifically, you did a good	Do state specifically what was done well and why that	Don't give general praise, "that was good,"

Step	Task	Purpose	Cue	Action	Do	Don't
		Reinforce behaviours beneficial to patient, colleague, or clinic.		job of…, and here's why it is important…"	is important.	because the key to effective feedback is specificity.
6	**Correct errors**	Teach learner how to correct the learning problem and avoid making the mistake in the future.	Teaching point has been delivered.	Ensure correct knowledge has been gained. "What would you do differently to improve your encounter next time?"	Do make recommendations for improving future performance.	Don't avoid confrontation—errors uncorrected will be repeated.
ONE-MINUTE REFLECTION						
Ask: "What did I learn about this learner?" "What did I learn about my teaching?" "How would I perform differently in the future?"						

Adapted from: Linda M. Roth, Ph.D., David L. Gaspar, M.D., John Porcelli, Ph.D., Department of Family Medicine, Wayne State University

The patient centred approach to bedside teaching is a particularly useful technique for a busy clinic setting.

- This technique decreases wait times. It can enable patients to get more attention from the health care worker and enable the health care worker to feel a level of empathy that can be hard to convey in a busy clinic setting where the health care provider is overwhelmed by patients and are working alone.
- It promotes a two-way learning environment.

Side-by-Side Teaching

This technique involves working alongside the mentee in clinic. The mentor and mentee alternate duties of seeing and examining the patients, writing relevant information in the patient's health record and or file, and checking lab results. The rationale for side-by-side teaching includes:

- Mentor can observe mentee at work and identify and address challenges.
- Mentor acts as a role model when s/he is performing a physical exam.
- Patients are seen more quickly than if the mentee sees the patients alone.
- Visits are more comprehensive and thorough.
- Mentees do not feel like they are being watched, but rather supported by a colleague.

Case Studies

In the case study method, a scenario is presented to learners followed by discussion questions about how to characterize, describe, and/or act on the situation in the scenario. The case study methodology thus enables the learner to develop analytic, problem-solving, and critical thinking skills in order to synthesize relevant information and make decisions. Case presentations are a good strategy to supplement bedside and side-by-side teaching. They are an effective way to engage all of the staff in a learning process, and they can be used to promote learning at more complex levels in both the cognitive and affective domains.

Case presentations provide an opportunity for health care workers to practice giving succinct summaries of patients, a skill required in the bedside teaching approach. Case presentations also allow health care workers to learn how their colleagues treated patients.

Six Steps for Creating an Effective Case Study:

1. Identify the learners and write educational objectives.
2. Describe the patient and develop sufficient case detail.
3. Focus the learner on discrete clinical decision points.
4. Present viable options at decision points.
5. Analyze options and select one course of action.
6. Introduce new information and continue to next clinical decision point.

Step 1. Identify the Learners and Write Educational Objectives

The development of effective educational material begins with consideration of the learner and her/his learning needs. A needs assessment identifies specific issues that may be challenging, confusing, or controversial to learners. See the box below for tips on assessing learners in advance of the teaching session, including on-the-spot sessions. If an opportunity does exist to assess learners in advance, it can be accomplished with a short questionnaire, email correspondence, or brief interviews with those planning to participate in the educational activity.

Needs Assessment: Learn More about Your Audience

During the planning phase:

- Send an email query to those likely to attend a session (ask two–three key questions).
- Make a phone call to several probable attendees.
- Have a discussion with a key informant about the group's general characteristics.
- Write a formal, short needs-assessment questionnaire.

On-the-spot:

- As the presentation begins, ask a few key questions; use a show of hands
- What is your educational training (MD, RN, etc.)?
- How many years have you been a health care personnel?
- What are the major conditions you see in your practice?
- Do you work with patients with HIV infection?

The focus of the case will depend on the learners and on the specific skills relevant to their medical practices. For example, a patient is admitted unconscious to the admission ward via the outpatient department. In this scenario the most important clinical decision to be made concerns the need for adequate nursing. To the physician the main object would be identifying the cause of coma. The focus of the scenario, therefore, depends on the needs and interests of the learners.

The actual design of a case begins with the creation of specific learning objectives once the learners and topic are defined. It is often more difficult to design objectives to fit an existing patient case scenario than to start with learning objectives and build a new case around them.

Learning objectives are words, pictures or diagrams that tell others what you intend for your students to learn.

A case study should have more than one objective. Often a series of objectives are addressed as the case unfolds. The clinical decision points of the case focus on the issues identified in the objectives.

Step 2. Describe the Patient and Develop Sufficient Case Detail

The first part of a case description provides baseline information on the patient and moves the learner toward the first clinical decision point. Key baseline information may include age, sex, HIV infection status, reported symptoms at presentation, recent medical history, relevant social history, findings from a physical examination, results of laboratory studies, and findings of a diagnostic workup.

The number of elements included in the case description depends on the complexity of the case and the information needed to stage the decision point. In general, the information should be as brief as possible while providing enough detail for the learner to make an informed clinical decision. It is important to provide enough information for the learners to make a justificed decision.

Step 3. Focus the Learner on Discrete Clinical Decision Points

Once the baseline information has been presented, the case study moves toward a clinical decision point. The purpose of the decision point is to focus learners' attention on discrete opportunities for informed decision making. It is important to develop a well-defined question that addresses an educational objective.

Step 4. Present Viable Options at Decision Points

It is important to present a number of relevant, mutually exclusive decision options to the learners. Each choice should be comparable to the others in terms of importance, plausibility, and level of detail.

If the decision points are being presented in a multiple choice fashion, it is important to create options that are grammatically similar and of roughly the same length. The longest option in a multiple choice set is often the preferred one because there is a natural tendency to explain and rationalize the preferred response in greater detail to the learner. It is also useful to avoid including the options "all of the above" and "none of the above" in multiple choice response sets. Instead, provide the learner with concrete, discrete choices.

Step 5. Analyze Options and Select One Course of Action

The instructor identifies the preferred response from among the multiple choices once learners have had a chance to consider (and possibly vote on) the alternatives. At this point, the case study presentation usually includes a brief lecture segment supporting the relevant clinical issues related to the preferred response. If available, new developments and current data supporting the preferred choice are presented. The current data are discussed in the context of the patient's situation, and the various options are contrasted and weighed.

Important parts of presenting the preferred response in Step 5 are the discussion and review of alternative options. This is an opportunity to present data and demonstrate the decision-making process.

Step 6. Introduce New Information and Continue to Next Clinical Decision Point

The previous steps describe one cycle of a case study through the resolution of a clinical decision point. The case can be used in its current length as a short case study, or it can be moved toward a second decision point on the same patient, i.e., new information from a follow-up appointment.

One benefit of following a single patient through a number of decision points is that it allows an audience or learner to quickly assimilate new information since the patient history is already known. Use of a continuing case reflects realistic dynamics of patient care. However, shorter case studies with one or two brief decision points have advantages, too. They may move a learner quickly through a variety of clinical situations.

Tips for Creating Effective Slides

- Give each Power Point slide a title. Titles help the audience quickly understand the main theme.
- Use as few words as possible to convey your point; help the audience focus on key points.
- Make your text large. Use titles with a minimum 36-point type size and text with a minimum 24-point type size. Do not use a slide that the audience cannot read.
- Use no more than eight words per line of text and no more than six lines of text on each slide.
- Minimize detail on tables and figures.
- Choose strong color contrast between the background and the text. Use light background color for a poorly lit room and dark background for a brightly lit room.
- Text drop shadows should be black or a darker shade of the background color.

Strategies for Optimizing Group Discussion

- Briefly clarify the purpose at the outset.
- Establish norms for group interaction at the outset; request ideas or suggest guidelines (ground rules) for effective small or large group functioning. Summarize or ask someone in the group to summarize the ground rules before moving on to another topic.
- Model the norms throughout (i.e., respect for differences of approach or opinion when no single correct course of action is determined).
- Do not reply or respond to each comment. Move to the next person wishing to comment or turn to the group for a response.
- Use the experience of the group as a resource for teaching.
- Actively invite ideas and suggestions.
- Plan your time to allow for real interaction.
- Do not introduce a controversial or emotionally laden topic without allowing sufficient time for a full discussion and resolution. If pressed for time, it is better to skip such content than to cut off discussion before opinions are expressed, full discussion has occurred, and a summary of points or ideas has been offered.
- Create a psychologically safe climate for learning that is free of threat and judgment. Showing patience and respect for differences of opinion, questions, comments, and responses and by avoiding disapproving, sarcastic or condescending reactions.

Exercise:

Form four groups and develop a case study on any topic of your choice following the steps provided in the previous session. Each group should then present their case study using Power Point slides (maximum 10 slides per presentation); if you do not have access to computers you can use flip charts for presentation. You will have up to 40 minutes for developing the case study and 20 minutes each for the presentation, critique and discussion.

Module Summary

1. Teaching moments are opportunities to improve clinical skills of a health care worker, can take place in a variety of settings, and mentors should maximize the number of teaching moments at a site visit.
2. Bedside and side-by-side teaching reinforce classroom learning and allow the mentor to model clinical technique, as well as appropriate attitudes and behaviours.
3. Case studies are an effective tool for clinical teaching.

Module 6.0: Clinical Mentorship Process

 **Duration: 1 hour**

Module Objective:

At the end of this module you should be able to:

- Describe the entire process of mentorship and follow the recommended guidelines to ensure a smooth clinical mentorship process

Facilitator's Session Plan for Module 6

Time	Session	Facilitation and active learning strategies
1 hour	The Mentorship Process	Presentation Interactive question and answer

Introduction

As a mentor, it is of utmost importance to master the entire process of mentorship. During the valuation of a mentorship cycle, the valuer will follow the process closely to check whether in fact it was followed closely through to completion. The process is in itself a quality assurance strategy, hence the need to observe its steps closely.

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Session 6.1 Mentorship Process

Session Objective:

At the end of this session, you should be able to:

- Describe the entire process of mentorship

Overview

Mentorship is the process whereby an experienced, highly regarded empathetic person (mentor) guides another individual (mentee) in the development and re-examination of her/his own ideas. It is also the process by which another individual is guided in learning and in her/his personal and professional development. The process is time-intensive and allows mentors to build relationships with their mentees. This adds to the anticipated overall level of positive changes.

Mentorship Process

Mentorship Teams

Formation of mentorship teams at national, provincial and district levels includes individuals already trained in mentorship with technical skills such as: IMCI, EmONC, ART/PMTCT, surgery, non-communicable diseases, etc. These teams will conduct mentorship in the various health service facilities across the country and at the different levels of health care services.

At hospital level (tertiary, secondary or primary), mentorship can take place in different departments. Therefore a mentorship team comprising of mentors with various technical skills, is needed.

At health centre level, the number of mentors needed at a given time, will depend on the staff complement and mentee needs.

Who receives mentorship visits?

Health care workers who have received in-service training should be visited for mentorship 6 -12 weeks after training. Other health care workers, who may not have received any specific in-service training but are working in specific focus areas (e.g. child health, obstetrics and gynaecology) and have been identified as needing technical support, can also be mentored.

How long is a mentorship visit?

Usually the minimum length of a mentorship visit is two days. However, this will vary depending on the mentorship focus area and the identified gaps. If much work is still needed with the mentee, the mentor can extend the mentorship or return at an agreed upon date. Similarly, if less work is needed to achieve the set objectives, then the mentorship visit could last less than two days.

How often should mentorship visits be done?

This is largely dependent on the area of focus and the skills to be mastered over time. For instance when working with knowledge and skills related to surgical procedures or complicated medical care, much repeated practice is needed and may take several mentorship sessions before skills are adequately acquired. Regular mentorship visits, not just one, build on the health worker's competencies, performance and overall quality of service delivery. Mentorship is not just a routine exercise, but is goal oriented and based on the needs of the mentee. Prudent use of resources (fuel, mentor-mentee time, allowances) should be considered when making decisions for future visits. After the first visit, further

visits are done based on an assessment of on-going needs and the availability of the mentor taking into consideration her or his other responsibilities.

It is **suggested** that the duration between mentorship visits should not exceed three months where possible, and if the mentee's skills' gaps are significant, shorter durations between visits are preferred. If the mentor and mentee are working at the same facility, the mentorship may be structured to accommodate the mentor and mentee's time so that time spent mentoring is spread out over a longer contiguous period.

Steps of the Mentorship Visit

1. Visit management team (provincial, district, health facility). Discuss the following:
    i. Purpose and objectives of visit.
    ii. Management team's roles and responsibilities.
    iii. Duration of current visit and proposed frequency of subsequent visits.
    iv. Tools/forms used to evaluate facility and mentee.
    v. If first visit, obtain further information on the general profile of the facility from the health facility management team to give mentor ideas for special focus during this and subsequent visits.
    vi. If not first visit, review findings and recommendations from previous mentorship report.
    vii. Arrange meeting time for post-mentorship visit feedback.

2. Prepare for the mentorship visit:
    i. Pre-mentorship site assessment prior to the first visit, where possible and necessary.
    ii. Review and bring previous mentorship report for facility and make a tentative plan of action based on the previous visit's findings and recommendations.
    iii. Collect and bring necessary reference materials and tools for the specific mentorship focus area such as:
        a) National Standard Guidelines
        b) Standard Operating Procedures
        c) Checklists for focus area
        d) Mentorship visit report

3. Prepare for activities with mentee
    i. Have a quick discussion with the mentee and other staff about:
        a) Why you are there (purpose and objectives of visit).
        b) Ask the team about general environment of the clinic (e.g., staffing, equipment, room space, communication issues, availability of resources and the relationship between the facility and the community and other stakeholders).
    ii. If not first visit, review findings and recommendations from previous mentorship report.
    iii. Ask for a guided visit. Areas to visit depend on the clinical mentorship focus area (example: if visit is for MCH areas, visit would include the maternity wing, pharmacy, lab and other relevant areas).
    iv. Discuss the entire mentorship programme with mentee (s).
        a) Identify areas upon which the mentee(s) wants to focus.
        b) Discuss roles and responsibilities of mentor and mentee.
        c) Develop a schedule for the visit.

d) Explains tools (clinical checklists as relevant to the clinical mentorship focus, evaluation of mentor tool) and approaches (pre and post-activity meetings, demonstration, coaching, and feedback) to be used during the process of mentorship.
e) Provide feedback (findings and recommendations) on the last day of the visit.

4. Conduct mentorship activities following agreed upon schedule
   i. Begin each subsequent day with pre-mentorship meeting.
      a) Check on what is happening in facility related to the clinical mentorship focus and other technical areas that may affect the mentoring process.
      b) Ask mentee if there are any further questions related to the previous day's tasks.
      c) Set the day's objectives and agree on a schedule for the day based on mentee's objectives and what is happening in the facility.
      d) Remind mentee to always use the checklist during the mentorship sessions.
   ii. Mentor and mentee work together to implement the planned mentorship activities.
   iii. End each day with a post-mentorship meeting.
      a) Skill review using skill checklists: Discuss feedback on clinical skills performed by the mentee using the evaluation/feedback process. Focus of this activity is to assist the mentee to improve clinical skills.
         - Ask mentee to give her/hisr own feedback on the skill.
         - Praise satisfactory points and then discuss areas needing improvement.
         - Offer suggestions of areas needing improvement.
      b) Case management review using the problem solving process: Ask mentee to present any interesting or difficult cases or an assigned case and make a plan of action to address the concerns raised.

5. Conclude mentorship visit
   i. Do an assessment process together with the mentee:
      a) Review objectives with mentee to see which were met.
      b) Identify objectives that were not met.
         - Identify why objectives were not met.
         - Suggest interventions to address objectives.
         - Agree on a timeline to meet objectives.
         - Agree on responsible person to meet objectives that was not met.
   ii. Debrief the provincial, district and hospital management teams or relevant in-charges.

6. Complete mentorship report

The mentor or mentor team writes the mentorship report at the conclusion of the visit. The report form to be used is in the next module. The report is distributed to the management team, the mentee, the mentee's supervisor, the mentor's supervisor, and the mentor keeps a copy.

Guide to the Mentorship Process

1. Building relationships

Establishment of a trusting and receptive relationship between the mentor and mentee (s) is the foundation for an effective mentoring experience. This component is ongoing over the course of the mentorship, as the relationship continues to evolve and grow.

2. Identifying areas for improvement

This component involves observation and assessment of existing systems, practices, and policies to identify areas for improvement. A number of tools that can help with this assessment phase have been developed. Information obtained during this assessment helps to inform the establishment of goals and objectives for the mentorship.

3. Responsive coaching and modeling of best practices

Mentors must demonstrate proper techniques and model good practices. During on-site mentoring, this means examining patients along with the mentee; using appropriate, systematic examination techniques with gloves when appropriate and hand washing. Mentorship is as much about setting a good example as it is about directly intervening to improve mentee practice.

4. Advocating for environments conducive to quality patient care and provider development

This component relates to technical assistance in support of systems-level changes at the site. Mentors work with colleagues to enhance the development of clinical site infrastructure, systems, and approaches that can support the delivery of comprehensive health care. For example, mentors might provide technical assistance in support of proper flow of patients at the facility, advocate for provision of privacy for patients during examination, or help to promote a multidisciplinary approach to health care at the site.

5. Collecting and reporting on data

Mentors should support the use and integration of patient data into clinical practice, and can help to demonstrate the utility of data collection and reporting to mentees during the mentorship.

Module Summary

- Mentorship is a process by which an experienced highly regarded empathetic person (mentor) guides another individual (mentee) in the development and re-examination of their own ideas.
- Mentorship teams should include individuals with various expertise such as IMCI, EmONC, ART, non-communicable diseases, etc.
- Health care workers with identified technical gaps can receive mentorship whether they have undergone a specific in-service training or not.
- The duration of mentorship depends on focus area and the identified gaps.
- If repeat mentorship is required, duration between visits ideally should not exceed three months.

Module 7.0: Mentoring Tools

 **Duration: 5 hours**

Module Objectives:

At the end of this module you should be able to:

- Describe competently the use of the tools
- Use the tools competently during practice sessions

Facilitator's Session's Plan for Module 7

Time	Session	Facilitation and active learning strategies
5 hours	Mentoring tools	Presentation Interactive question and answer Brainstorming Group work

Session Instructions:

This module provides the tools to be used during mentorship including the reporting format as well as discipline specific tools. The module contains important competencies that each practitioner in her/his specialist area should be able to carry out as a matter of routine. It is important that you ensure that the trainee mentors do not just rush through but must attain the competence under your close supervision. Where need be, please take remedial action so that your mentee is confident on each task assigned.

The trainee mentor needs to master all the general mentoring tools. However, depending on the competencies required for the trainee mentor to acquire, not all the discipline specific tools need to be reviewed; concentrate on the one(s) that address the required competencies. For instance, when training IMCI-specific mentors, the IMCI tool is the main discipline specific tool to be reviewed in addition to the general tools.

Because the modules that precede module 7 provide general concepts on mentorship, this training package may be used to train mentors in other technical areas that may not be currently included in this module such as nutrition, paediatric ART and human resource management. The tools developed for these technical areas can be the main focus when reviewing the discipline specific tools but the general mentorship tools will still be applicable in this instance.

Tools included for review in this module are:

Mentorship training tools:

- Daily evaluation tool
    - his tool is used during the training by participants to evaluate the day's proceedings. Rapporteurs for the day summarise the entire group's feedback and provide a brief five minute presentation the following morning.

- Trainee mentor skills/competency checklist
    - This tool is used during training by the facilitator to assess a trainee mentor's competence to be an effective mentor. It is to be used at the end of the mentorship training after the facilitator has observed the trainee mentor practice conducting mentorship during the practicums. Feedback is provided to each trainee mentor based on the facilitator's assessment.

General mentorship tools:

- Mentoring Procedure Checklist
    - This tool provides the steps to be taken by the mentor during a mentorship visit including the protocols to be observed.
- Mentorship Visit Evaluation Tool
    - This tool is to be used during a mentorship visit by the mentee to provide feedback on the mentorship visit as a whole and evaluate the mentor.
- Mentoring Visit Report
    - This tool is used by the mentor; it provides the format for writing the end report.
- Coaching Skills Checklist
    - This tool is to be used by the mentor during a mentorship visit; it provides a guide to coaching a mentee, doing demonstrations and return demonstrations and conducting a case study during a mentorship visit.
- Mentee Skills Acquisition Summary
    - This tool is used by the mentor during mentorship as a companion to the technical area specific tools; it summarizes the acquisition of skills by the mentee over a single mentorship visit or across several mentorship visits.

Technical/discipline-specific mentorship tools:

These tools are used by the mentor to assess the competency of an HCW in the technical area of focus.

1. Pregnant adolescent/adolescent reproductive health
2. Focused antenatal care and gynaecology
3. Family planning
4. Intra-partum care and neonatal resuscitation assessment
5. Internal medicine
6. Surgery
7. IMCI
8. Laboratory assessment
9. Tools for nurses and midwives
10. Paediatric care
11. Pharmacy
12. Paediatric ART
13. Adult ART
14. Advanced HIV Care
15. Psychiatry
16. Nutrition
17. The well child/ HIV exposed
18. Data quality
19. Physiotherapy

20. Radiology
21. Anaesthesia
22. Others

Note: Mentorship tools from numbers 12 to 21 are still being developed by the relevant departments of the MOH.

Ministry of Health

Generic Mentorship Training

Daily Evaluation Form

	Date				
Comment					
What did you enjoy the most today? *(not restricted to formal teaching*)					
What did you dislike the most today? *(not restricted to formal teaching*)					
What did you learn from today's sessions that you think you will use in your work?					
Was there anything you did not understand from today's sessions?					
Other comments					

Ministry of Health

Trainee Mentor Skills: Competency Checklist

Date: _____ **Facilitator: _____**

Mentee: _____ **Mentorship Area: _____**

Please rate the trainee mentor's demonstrated skills using the rating scale below. Place the rating for each step every day/time you observe the competency area and note the date in the section indicated "date" directly above the row for rating; it is advisable that each column in the rating section corresponds to the same day.

1 – Trainee mentor shows competence or strength in this area
2 – Trainee mentor demonstrates some ability in this area
3 – Trainee mentor needs additional support in this area
4 – Not observed
5 – Not applicable

	Date				
Skill	**Rate**				
Overall mentorship delivery skills					
Greeted mentee warmly					
Clearly described mentorship expectations					
Summarized main points at the end					
Thanked mentee					
Communication skills					
Maintained good eye contact with mentee					
Faced mentee					
Spoke clearly, loudly, and not too fast					
Used simple language that is understood by all					
Used name(s) of mentee(s)					
Was friendly and smiled appropriately					

	Date				
Skill	**Rate**				
Provided mentee with positive reinforcement and suggestions for improvement					
Handled questions calmly and with courtesy					
Clarified and rephrased questions					
Technical competency					
Provided technically sound information					
Gauged mentee level of technical knowledge and adjusted session accordingly					
Comments:					

Ministry of Health

Mentoring Procedure Checklist

Mentoring Procedure Checklist			
Steps	**Completed /Date**	**Not Completed**	**Comments**
Provincial/District/Hospital Management Visit Discuss the following:			
a. Purpose and objectives of visit			
b. Management teams roles/ responsibilities in the mentorship process			
c. Mentorship tools/forms used to evaluate facility and mentee			
d. Obtain information on general facility profile to obtain ideas for special focus			
e. If not first visit, review findings and recommendations from previous reports			
f. Arrange meeting time for post-mentorship visit feedback.			
Site and Mentee Assessment			
a. Discuss programme with staff:			
i. Purpose and objectives of visit			
ii. Roles / responsibilities of mentor and mentee			
iii. Explain tools and approaches			
iv. Identify areas upon which mentees want to focus			
b. Pre-mentorship site assessment (patient flow, staff, equipment, communication, HMIS, etc.) prior to the first visit, where possible and necessary. Ask for guided visit to area of focus.			
c. Mentee assessment- (case record review, case observation, other activities)			
d. Mentee completes evaluation form			
e. Mentorship visit report			
Mentoring Visit			
a. Collect and bring necessary reference materials and tools for specific mentorship focus areas, i.e., national guidelines, SOPs, checklists for focus areas, mentorship report			
b. Pre-mentorship meeting with staff and			

Mentoring Procedure Checklist			
Steps	**Completed /Date**	**Not Completed**	**Comments**
mentee – purpose/objective of visit, list of areas to work in, areas mentee would like focus on, roles and responsibilities of mentee / mentor, tools, etc.			
c. If this is a repeat mentorship visit, review findings from previous visit and progress made on recommendations			
d. Work with mentee to implement planned mentorship activities			
e. End mentorship visit with post-mentorship/debrief meeting – review of objectives and identifying those not met, review findings and make recommendations with time-frame and responsible persons, etc.			
f. Ensure mentee completes evaluation form			
g. Debrief provincial / district / hospital teams at the end of the exercise			
h. Complete mentorship report			
i. Distribute mentorship report to relevant personnel			

Ministry of Health

Mentee Mentorship Visit Evaluation Tool

Date: _____ Name of mentor_____

Name of mentee_____

Key to scoring

Instructions to mentee: Please tick (✓) to indicate your opinion of the mentorship using the following rating scale:

5-Strongly Agree 4-Agree 3-No opinion 2-Disagree 1-Strongly Disagree

Evaluation Form	Rating				
	5	4	3	2	1
Mentorship Visit					
1. List the mentorship visit objectives below and indicate if the objectives were met in the column to the right					
Mentor as a Role Model					
2. Modelled cognitive, psychomotor, ethical and professional behaviour					
a. Knowledgeable					
b. Skilled					
c. Respectful to clients and mentee					
d. Honest					
e. Reliable					
f. Punctual					
g. Self-confident					
h. Empathetic					

Evaluation Form	Rating				
	5	4	3	2	1
i. Non-judgmental					
3. Mentor committed to self-learning and learning of others					
Administration of Mentor					
4. Prepared teaching equipment and supplies needed for mentoring in a timely manner					
5. Conducted daily pre-mentorship meetings					
6. Conducted post mentorship meeting as required					
7. Prepared mentorship visit report					
8. Identified and managed conflicts					
Teaching and Learning by Mentor					
9. Discussed expectations of the relationship with the mentee at the beginning					
10. Discussed goal of mentorship visit					
11. Established mutually agreed upon objectives					
12. Created a healthy learning environment					
13. Helped mentee develop own agenda for working and learning					
14. Recognized and supported the mentee's strengths and areas to be developed through timely feedback					
15. Encouraged creativity and innovations					
16. Used mentoring skills:					
a. Role modelling					
b. Coaching					
c. Demonstration and return demonstration					
d. Review of case studies					

Ministry of Health

Mentoring Visit Report Format

Mentoring Visit Report				
Name of Mentor				
Focus Area of Mentorship				
Province			**District**	
Facility Name				
Reporting Period				
1. Introduction **Mentee Profile**				
Name	**Profession**	**Relevant in-service training attended (if applicable)**	**Year in-service training attended**	**Comments**
Background information (e.g., services provided, organizational issues, human resources, equipment, supplies, referral system)				
Issues from management team on mentee (s)				
Purpose of visit				
Specific objectives				

Mentoring Visit Report	
2. Mentorship process (list specific activities undertaken)	
3. Accomplishments (including number of cases managed with mentee)	
4. Challenges and proposed solutions	
Challenges	**Proposed solutions**
5. Conclusion (overall perception of the entire visit)	

Objectives not met	Why objective not met	Recommendations to meet objectives	Timeline to meet objectives	Person responsible

Note: Do not be limited by space provided when writing the report; please expand all relevant sections as necessary.

Ministry of Health

Coaching Skills Checklist

Coaching Skills Checklist
Instructions: Place the rating for each step everyday/time you observe the step and note the date in the section indicated "date" directly above the row for rating; it is advisable that each column in the rating section corresponds to the same day. Place an "**S**" in case box indicated "rating" if step/task is performed **satisfactorily**, an "**X**" if it is **not** performed **satisfactorily**, **N/O** if not observed or **N/A** if it is **not applicable**. **Satisfactory**: Performs the step or task according to the standard operating procedure or guidelines **Unsatisfactory**: Unable to perform the step or task according to the standard procedure or guidelines **Not Observed**: Step or task not performed by participant during evaluation by trainer **Not Applicable:** Step or task is not applicable to mentorship session being conducted

Coaching Skills	DATE					
STEPS	**RATING**					
BEFORE PRACTICE SESSION						
1. Greet mentee.						
2. Ask mentee to look at the learning guide to review previous practices and to decide areas that need improvement.						
3. Work with the mentee to set specific goals for the practice session.						
4. Review any difficult steps or tasks in the learning guide that will be practiced during the session.						
5. Agree with mentee on communication method to be used during coaching when mentee is giving care to a client.						
DURING PRACTICE SESSION						
6. Observe the mentee as s/he practices the procedure.						
7. Provide positive reinforcement and suggestions for improvement as the mentee practices the procedure on a model.						
8. Refer to the learning guide during observation.						
9. Record notes about mentee performance during the observation.						
10. Is sensitive to client when giving feedback to mentee in front of client.						
11. Mentor should come in when the comfort or safety of the client is in doubt.						
AFTER PRACTICE FEEDBACK SESSION						
12. Thank or congratulate mentee for her performance, if applicable.						
13. Ask mentee to share feelings about the practice session.						
14. Ask mentee to identify those steps performed well.						
15. Ask mentee to identify steps that could be improved.						
16. Refer to notes on the learning guide.						
17. Provide positive reinforcement regarding those steps or tasks the mentee performed well.						
18. Offer specific suggestions for improvement.						
19. Work with the mentee to establish goals for the next practice session.						
Comments:						

Demonstration and Return Demonstration	***DATE***					
STEPS	**RATING**					
Preparation and Planning:						
1. If demonstration in clinical area, ensure client understands and obtain consent from client.						
2. If demonstration is not in clinical area, arrange area/seating so everyone can see.						
3. Have equipment/materials ready for demonstration BEFORE starting the demonstration.						
4. Review the *learning guide before the demonstration.						
5. Plan adequate time to do the demonstration and return demonstration.						
Demonstration Steps:						
6. DO NOT demonstrate incorrect steps or short cuts.						
7. If using a model, position model as an actual client.						
8. Make the client/model comfortable. You could ask the mentee to take the role of the client during a demonstration.						
9. Ask questions and encourage mentees to ask questions.						
10. Include correct infection prevention practices in the demonstration						
11. Use good communication skills during demonstration: • Speak clearly, loudly, and not too fast • Use simple language that is understood by all • Face mentee • Use names of mentees and/or client • Make regular eye contact with ALL mentees • SMILE appropriately						
12. Ask mentee to follow demonstration with her/his own *learning guides.						
13. Use your own skill checklist and reference manual.						
14. Give a short introduction, stating the skills and objectives for the demonstration.						
15. Do a slow demonstration of the complete skill. • SHOW each step and SAY what you are doing as you begin each step. • At the end of the demonstration, ask if there are any questions.						
16. Repeat demonstration of the skill in parts						
17. Repeat demonstration of the complete skill at a speed the skill is normally done.						
18. Ask a mentee to do the first return demonstration.						

Coaching Skills	**DATE**					
STEPS	**RATING**					
19. Ask mentee who conducted the exercise to give own feedback.						
20. Ask observing mentee(s) to give feedback.						
21. Provide the mentee with constructive feedback .						
22. Divide mentees into groups, if there are many mentees						
23. Ask each mentee to do a return demonstration of the skill as stated in the learning guide and then do a feedback process.						
24. Mentor to observe each mentee/group and give feedback as needed.						
Comments:						

Conducting a Case Study

STEPS	DATE				
Preparation:	RATING				
1. Ask mentee to prepare a case study on one of his/her clients.					
2. Ask mentee to put his/her case study on a flip chart or to do a PowerPoint presentation.					
3. Explain that the case study should be organized according to the problem solving process (history, physical examination, diagnosis, management, evaluation).					
4. Review case study in a quiet place away from client areas.					
5. Arrange seating in semi-circle or where mentees can see each other and the mentor and with a place for the mentees to write.					
6. Plan about 30 – 45 minutes to do the case study.					
Procedure:					
7. Begin by introducing the topic.					
8. Describe the way the discussion will proceed (mentee will present, then observing mentees will give feedback [positive feedback and areas needing improvement], followed by the mentor who will also give feedback). Ask observing mentees to listen carefully and to write notes about their thoughts during the presentation.					
9. The mentee who prepared the case study presents.					
10. Mentor takes notes for later feedback.					
11. When the mentees has finished with the case study, thank the mentee.					
12. Ask the observing mentees for feedback.					
13. Encourage all mentees to actively participate by asking them questions.					
14. If mentees do not come up with the best or all of the answers, add to what they have said.					
15. Do not allow mentees to become embarrassed if they give incorrect answers. Remind them that everyone is here to learn.					
16. Praise mentees for their contributions.					
17. At the end of the case study, the mentor or a mentee reviews the problem solving steps and summarizes the topic.					
18. Thank mentees for their participation.					
Comments:					

Ministry of Health

Mentee Skills Acquisition Summary

Please summarize the mentee's demonstrated skills acquisition over the period of the mentorship using the rating system below. This tool can be used for tracking skills acquisition during a single mentorship visit or over several mentorship visits.

Mentor: _____ **Mentee Name: _____**

Mentorship Period: ___/___/_____ to ___/___/_____ **Mentorship Area: _____**

Rating Scale:

1 – **Not demonstrated /** No demonstration of skills, needs complete/full training
2 – **Partial demonstration:** Demonstrates some strengths/skills in area, needs to strengthen skills in some areas
3 – **Demonstrated***:* Demonstrates excellent strengths/skills in this area

	Date				
Competency Area	**Rate**				
History taking					
Professional/interpersonal skills					
Clinical examination					
Clinical diagnosis					
Clinical management (investigations, care, treatment)					
Referral					
Other (specify)					

Ministry of Health

Laboratory Mentee Skills Acquisition Summary

Please summarize the mentee's demonstrated skills acquisition over the period of the mentorship using the rating system below. This tool can be used for tracking skills acquisition during a single mentorship visit or over several mentorship visits.

Mentor: _____ **Mentee Name:** _____

Mentorship Period: ___/___/_____ to ___/___/_____ **Mentorship Area:** _____

Rating Scale:

1 – Not demonstrated / No demonstration of skills, needs complete/full training
2 – Partial demonstration: Demonstrates some strengths/skills in area, needs to strengthen skill in some areas
3 – Demonstrated: Demonstrates excellent strengths/skills in this area

	Date				
Competency Area	**Rate**				
Specimen reception and handling					
Quality Control (before running tests and/or incorporated during testing					
Laboratory testing					
Documentation of QC activities and all other laboratory data generated					
Analysis/verification and interpreting laboratory results before release					
Application of laboratory commodity management skills					
General laboratory management and responsibility					
Other (specify)					

Ministry of Health

Clinician Mentorship Tool - Pregnant Adolescent

Mentee Name/s: _____ **Mentee/s Qualifications:** _____

Site: _____ **Mentor:** _____

Month/Year: _____

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – Not demonstrated / No demonstration of skills, needs complete/full training

2 – Partial demonstration: Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – Demonstrated*:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed, i.e., 'not applicable,' to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; 50 – 75% - requires further mentoring in specified technical area or specialty; 75% and above – demonstrates good skills and does not require further mentoring in that area.

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
• **Interaction with the adolescent**	1. Did not greet or make the adolescent welcome, was judgmental, did not use simple and clear language, and did not understand adolescent difficulties in communicating topics related to sexuality. 2. Limited use of the above parameters. 3. Complete and appropriate use of the above parameters.	
• **Confidentiality**	1. Did not assure adolescent of confidentiality. 2. Assured adolescent of confidentiality.	
• **Discussed adolescent situation**	1. Did not find out if adolescent lives with parents, is part of a couple or in a relationship, did not find out who else knows about the pregnancy and if she is a subject of sexual violence. 2. Discussed the above parameters but did not exhaust all the parameters. 3. Complete and appropriate use of the above parameters.	
• **Supported adolescent's concerns**	1. Did not discuss t concerns, i.e., physical, socio- economic, psychological. 2. Discussed only one to two of the above parameters. 3. Covered all the aspects.	
• **Discussed prevention of STI/HIV/AIDS**	1. Did not discuss condom use and other information on STIs/HIV prevention including mother to child transmission of HIV. 2. Discussed only condom use. 3. Discussed all the parameters.	
• **Discussed options after delivery**	1. Did not offer counselling on contraception, continuing education/career or family support. 2. Counselled client only on one or two of the above parameters. 3. Counselled client on all the above parameters.	
• **Overall score (%)**		

NB- Birth Plan as per normal ANC care plan

Areas for improvement/current challenges:

Action Plan for person to improve identified areas for improvement::

Suggested date for next assessment: _____

Ministry of Health

Clinician Mentorship Tool - Focused Antenatal Care and Gynaecology

Mentee Name/s: _____ **Mentee/s Qualifications: _____**

Site: _____ **Mentor: _____**

Month/Year: _____

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – **Not demonstrated /** No demonstration of skills, needs complete/full training

2 – **Partial demonstration:** Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – **Demonstrated***:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed, i.e., 'not applicable,' to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; **50 – 75%** - requires further mentoring in specified technical area or specialty; **75% and above** – demonstrates good skills and does not require further mentoring in that area.

Section A: This section is applicable for assessing mentees in focused antenatal care and gynaecology

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	
Identified the patient	1 - Did not ask about the last menstrual period, age and parity 2 - Inquired only one or two of the above 3 - Patient identified all the above parameters	
Chief complaints asked and recorded including the duration of the problem	1—No questions asked 2—Questions asked, but only related to positive symptoms 3—Questions asked relating to both positive and negative symptomatology	
Past medical/surgical history taken	1- Past medical and surgical history not elicited 2- Limited past medical/surgical conditions elicited, i.e., epilepsy, diabetes, hypertension, asthma 3- Comprehensive elicitation of past medical/surgical conditions	
Family history is taken and recorded	1— No family history taken 2— Limited to details of individual patient only 3—Details of family history, co-morbid medical conditions and genetic disorders	
Drug history taken comprising current, previous medication, side effects, toxicity, allergy, and herbal/traditional concoctions	1—Limited to current medication with some previous medication details 2—Current and recent past medications, dosage and duration elicited 3—Toxicity, side effects, compliance and adherence elicited in addition to above	
Personal history taken with emphasis on diet, addiction habits (smoking, alcohol, narcotics etc.)	1—Limited to diet history, no personal habits enquired 2—Details of smoking (type, number, duration), alcohol consumption (type, amount, duration) 3—Addicting drugs in addition to above, all patients	
Sexual history taken	1—History of exposure elicited, no privacy or confidentiality 2—Details of sexual exposure (premarital, extra marital), history of STI's and treatment given (previous/current genital ulcer, discharge, bubo, etc.) 3—Use of barrier contraceptives, route of penetration (anal, oral), privacy (utilises side room) and confidentiality (informs patient history is confidential)	
Documentation accurate, complete and timely for every consultation including completion and appropriate medical forms	1—Documentation not done 2—Partially complete documentation 3—Documentation complete	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	
Total score for history taking section (%)		
Professional/ Interpersonal Skills		
Patient- centred (listens to patient's ideas and concerns)	1—Welcomes the patients and offers seat to patient 2— Body language appropriate, empathetic (listens to patient) 3—Open ended questions, encourages patient	
Privacy and confidentiality is maintained while taking sensitive histories	1—No elicitation of sensitive history/risk taking behaviour 2—Elicits sensitive history using appropriate open ended and close ended questions 3–Elicits sensitive history and utilises side room (privacy)	
Uses team approach (shares information with team members)	1—No coordination /communication with team members 2—Consults specialist physician when needed, handles consultations, instructs staff nurses, in addition to above 3- Organises support systems, mentors colleagues	
Practices ***universal precautions for infection prevention***	1—No advise on infection control measures to patients 2—Advises and practices cough hygiene, hand washing, use of gloves for individual patients. 3—Ventilation adequate, segregation/disposal of waste	
Total score for professional/interpersonal skills (%)		
Clinical Examination and Assessment		
Checks that vital signs are recorded and attends to comfort of patient at rest	1—No recording of vital signs 2—Recording of some vitals (temperature, respiratory rate, blood pressure, pulse) using appropriate method 3—Recording of all vitals and ensures patient's comfort	
General examination adequate including examination from head to toe, looking for signs of internal disease	1—No examination 2—Performs limited general examination, e.g., anaemia, clubbing 3—Thorough general examination with privacy	
Systemic examination – cardiovascular system	1 - No cardiovascular examination 2—Limited cardiovascular examination 3— Comprehensive cardiovascular examination	
Systemic examination – respiratory system	1 - No respiratory examination 2—Limited respiratory examination 3— Comprehensive respiratory examination	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	
Systemic examination-abdomen	1 - No examination 2—Limited abdominal examination 3— Comprehensive abdominal examination	
Systemic examination –genital examination	1—No examination of genitalia 2—Inspection of external genitalia 3—Inspects genitalia and where applicable inserts sterile proctoscope /vaginal speculum	
Systemic examination –central nervous system (CNS), peripheral and autonomic systems	1—No examination 2—Limited CNS examination 3— Comprehensive CNS examination	
Total score for examination section (%)		
Clinical Diagnosis and Laboratory Assessment		
Makes ***provisional / differential diagnosis***	1—No diagnosis 2—Incorrect /incomplete diagnosis made 3—Correct and complete diagnoses noted	
Lab tests ordered as ***appropriate***	1—No tests ordered 2—Some/inappropriate tests ordered 3—All relevant tests ordered	
Checks results (current and previous) of laboratory and verify documentation, ***interprets*** results correctly leading to appropriate action	1—No verification 2—Incomplete /incorrect interpretation and documentation 3—Complete /correct interpretation and documentation with appropriate action done	
Total score for clinical diagnosis laboratory section (%)		
Clinical Care and Treatment		
Client management plan	1—No client management plan 2—Incorrect /incomplete management plan 3—Complete and correct management plan implemented according to protocols	
Recognise when client needs acute care for life threatening complications	1—No recognition/action 2—Incorrect or incomplete action taken 3—Appropriate complete measures taken	
Manages ***other co-morbid***	1—No management of other co-morbid conditions/chronic illnesses	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	
conditions	2—Incorrect/incomplete management of chronic illness/co –morbid conditions, according to guidelines 3—Able to manage/seeks specialist advice	
Knows when to seek guidance from supervising clinician	1—Does not seek guidance when necessary 2—Seeks appropriate guidance when necessary	
Advises on use of local sources of nutritious food, drug- food interactions if any	1—No advice given 3—Advises on local sources of nutritious food 3—Advises on drug –food interactions if any, emphasizes on adherence related to meals	
Total score for clinical care and treatment section (%)		
Referral/link to other health and supportive services and follow up		
Seeks specialist advice or refers or links patient to appropriate health /supportive service HIV care	1—No discussion/ referral 2—No discussion but refers appropriately 3—Discusses at length about reason for referral and refers appropriately	
Advises on clear plan for individual patient care	1—No care plan 2—Advises on care plan but does not provide information on follow up issues 3— Advises on care plan and provides information on follow up issues	
Total score for follow up / referral section (%)		
Section B: This section is applicable for focused antenatal care (FANC) specific mentoring		
Current pregnancy status	1 – Questions not asked on danger signals 2 – Some questions asked on danger signals 3 - Comprehensive questions asked on current pregnancy status including danger signals	
Past obstetric history	1 – Questions on past obstetrical history not elicited 2 - Limited questions on past obstetrical history 3 - Questions on past obstetrical history including risk factors elicited	
Complication, readiness and birth preparedness	1 - No mention of either complication readiness or birth preparedness 2 – Only one of the two mentioned 3 - Both complication readiness and birth preparedness mentioned	
Information and communication	1 – None given on PMTCT ,intermittent preventive therapy (IPT), deworming 2 - Limited information given on PMTCT, IPT and deworming 3 - Complete information given on PMTCT, IPT and deworming	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	
Obstetric examination	1- No examination 2 – Performs limited obstetric exams 3 – Performs thorough exam according to protocols including identification of risk factors	
Urinalysis (and interpretations done)	1- Urinalysis not done 2- Urinalysis done 3- Urinalysis done and interpretations correctly done	
IPT, haematinics, deworming in pregnant women	1- No use of IPT, haematinics, vermox 2- Uses IPT, haematinics, vermox at appropriate times	
Advises on ***breastfeeding, infant and young child feeding*** to caregivers	1- No advice given 2- Limited advice on breastfeeding and feeding of children 3- Comprehensive advise on breastfeeding, infant and young child feeding including the context of HIV	
Total score FANC specific section (%)		
Section C: This section is applicable for Gynaecology specific mentoring		
Present gynaecological history is taken	1—Elaboration of chief complaints only (development of symptoms) 2—Sequential, chronological elicitation of symptoms using open ended and close ended questions with some patients 3—Symptom analysis, positive and negative symptoms, all major systems (CVS, RS, abdomen, CNS) covered, all symptoms analysed in chronological order	
Reproductive/antenatal history	1--Limited to chief complaints only, not dealing with co-morbid medical complaints 2—Past reproductive and antenatal history enquired into, past symptoms related to relevant symptoms, some patients 3—Past reproductive, screening of cancer of the cervix, and antenatal history along with co-morbid medical conditions, previous surgical conditions, blood transfusions, and drug allergies recorded, all patients	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	
Total score Gynaecology-specific section (%)		
Overall score (%)		

Areas for improvement/current challenges:
Action Plan for person to improve identified areas for improvement:
Suggested date for next assessment: _____

Ministry of Health

Clinician Mentorship Tool – Family Planning

Mentee Name/s: _____ **Mentee/s Qualifications: _____**

Site: _____ **Mentor: _____**

Month/Year: _____

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – **Not demonstrated /** No demonstration of skills, needs complete/full training

2 – **Partial demonstration:** Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – **Demonstrated***:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed, i.e., 'not applicable,' to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; **50 – 75%** - requires further mentoring in specified technical area or specialty; **75% and above** – demonstrates good skills and does not require further mentoring in that area.

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Create a relaxing atmosphere	1- Did not greet, smile, use eye contact or positive body language 2- Limited use of the above parameters 3- Complete and appropriate use of the above parameters	
Communication technique	1- Did not use open ended questions, explanation in simple language or good listening skills 2- Limited use of the above parameters 3- Complete and appropriate use of the above parameters	
Explore relevant history (profiling)	1- Did not elicit reproductive, menstrual, contraceptive, STI, and medical/surgical histories 2- Limited use of the above parameters 3- Complete and appropriate use of the above parameters	
Explanation of family planning methods	1- Did not explain benefits, side effects, effectiveness, mode of action, how to use method 2- Limited explanation of above parameters 3- Complete and correct explanation of the above parameters	
Feedback from client	1- Did not ask if client has questions, did not get informed consent, did not provide a method and did not thank the client. 2- Methods explained but no feedback from client 3- Complete and appropriate use of the above parameters	
Return visit	1- Did not ask how client is coping with method or find out any adverse side effects and did not offer more supplies/alternative method 2- Limited use of above parameters 3- Complete and appropriate use of the above parameters	
Practices ***universal precautions***	1- Limited /no advice on infection control measures to patients 2- Advises and practices cough hygiene, hand washing, use of gloves for individual patients 3- Ventilation adequate, segregation/disposal of waste, supervises and performs infection control procedures	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Total score (%)		

Areas for improvement/current challenges:

Action Plan for person to improve identified areas for improvement:

Suggested date for next assessment: _____

Ministry of Health

Clinician Mentorship Tool – Intra-partum Care and Neonatal Resuscitation Assessment

Mentee Name/s: _____ **Mentee/s Qualifications:** _____

Site: _____ **Mentor:** _____

Month/Year: _____

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – **Not demonstrated /** No demonstration of skills, needs complete/full training

2 – **Partial demonstration:** Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – **Demonstrated***:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed, i.e., 'not applicable', to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; **50 – 75% -** requires further mentoring in specified technical area or specialty; **75% and above** – demonstrates good skills and does not require further mentoring in that area.

Section A: Intra-partum Care

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Initial Assessment		
Identify client particulars	1- No gestation a age, parity, gravida given 2- Limited mention of above particulars 3- Complete identification of client's gestation age, parity, gravida	
History of this labour	1- Onset of labour, rupture of membranes, any vaginal bleeding, perception of foetal movements not elicited 2- Limited information of the above given 3- Comprehensive information related to this labour elicited	
Current pregnancy status	1. Antenatal card not reviewed for any problems 2- Antenatal card reviewed but some information not applied to patient's needs 3- Antenatal card reviewed and appropriate action taken	
Review of birth plan	1- Birth plan not reviewed 2- Birth plan reviewed but not discussed with client 3- Plan reviewed and discussed with client and appropriate action taken	
Review past obstetric history	1- Past obstetric history relating to previous operation, difficult labours, still births not reviewed 2- Past obstetric history reviewed, but no appropriate action taken 3- Past obstetric history reviewed and appropriate action taken	
Perform general examination	1- No vitals taken, temperature, BP, pulse, respiratory rate	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
	2- Some vitals recorded 3- All vitals including urinalysis recorded	
Perform obstetric examination	1- Fundal height, presentation, lie, liquor volume, foetal heart rate not done 2- Some of the parameters done 3- Complete performance of above parameters	
Vaginal assessment	1- Not done to assess stage of labour, state of membranes, presenting parts, and adequacy of pelvis 2- Some parameters not assessed 3- Complete performance of above parameters	
Monitoring progress of labour	1- Partograph not opened to monitor progress of labour 2- Partograph opened but incorrect/incomplete entries 3- Partograph opened, correct entries and appropriate monitoring	
Second stage of labour	1- Clean/safe delivery protocols not followed 2- Some clean and safe delivery protocols followed 3- All clean and safe delivery protocols followed	
Third stage of labour	1- No active third state of labour observed 2- Not all steps/protocols followed in the active third stage 3- All steps/protocols followed in the active third stage	
Documentation	1- No documentation on events of labour 2- Incorrect/incomplete documentation 3- Complete documentation of all events of labour	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Feedback to client/accompanying person	1- No feedback given on the events of labour 2- Incorrect/Incomplete feedback given 3- Complete feedback given on the events	
Total score for intra-partum care (%)		
Section B: Neonatal Resuscitation		
CALL		
Call for help	1- No help sought 2- Help sought after starting resuscitation 3 -Help sought and individuals assigned tasks prior to resuscitation.	
Initial assessment of baby	1- Baby not checked for breathing, heart beat, air way, and warmth 2. Only one or two parameters above checked 3 Complete assessment of all the above parameters	
Steps in newborn resuscitation	1- Did not follow the newborn resuscitation protocol, keep baby warm, open airway and ventilate 2- Incomplete/incorrect newborn resuscitation protocols 3- Steps in new born resuscitation correctly and timely	
Handling of resuscitation outcome	1- Did not explain and record events and did not refer to advanced neonatal care 2- Limited action above taken. 3- Complete and appropriate action above taken	
Total score for neonatal resuscitation (%)		
Overall score (%)		

Areas for improvement/current challenges:

Action Plan for person to improve identified areas for improvement:

Suggested date for next assessment: _____

Ministry of Health

Clinician Mentorship Tool - Internal Medicine

Mentee Name/s: _____ **Mentee/s Qualifications:** _____

Site: _____ **Mentor:** _____

Month/Year: _____

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – **Not demonstrated:** No demonstration of skills, needs complete/full training

2 – **Partial demonstration:** Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – **Demonstrated***:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed, i.e., 'not applicable', to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; **50 – 75%** - requires further mentoring in specified technical area or specialty; **75% and above** – demonstrates good skills and does not require further mentoring in that area.

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Initial Assessment		
Presenting complaints **-** asked and recorded including the duration of the problem	1- No questions asked 2- Questions asked, but only related to positive symptoms 3- Questions asked relating to both positive and negative symptomatology	
History of presenting complaints is taken -sequential, relevant to chief complaints and they are recorded	1- Elaboration of chief complaints only (development of symptoms) 2- Sequential, chronological elicitation of symptoms using open ended and close ended questions (review of presenting system) 3- Symptom analysis, positive and negative symptoms, all major systems (cardiovascular system, respiratory system, abdomen, CNS) covered, all symptoms analysed in chronological order (complete systemic review)	
Past medical history	1- Limited to chief complaints only, not dealing with co-morbid medical complaints 2- Co-morbid medical conditions (diabetes, asthma, epilepsy, tuberculosis) enquired into, past symptoms related to relevant symptoms 3- Co-morbid medical conditions, along with previous surgical conditions, blood transfusions, developmental and immunization history and drug allergies recorded	
Drug history is taken comprising current, previous medication, side	1- No/limited to current medication with some previous medication details	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
effects, toxicity, allergy, and herbal/traditional concoctions	2- Current and recent past medications, dosage and duration elicited 3- Toxicity, side effects, compliance & adherence elicited in addition to above	
Family history is taken and recorded	1- Limited to details of individual patient only 2- Details of family history, spouse and children 3- Details of family history, co-morbid medical conditions and genetic disorders	
Social economic history taken with emphasis on diet, addiction habits (smoking, alcohol, narcotics, etc.)	1- Limited to diet history, no personal habits enquired 2- Details of smoking (type, number, duration), alcohol consumption (type, amount, duration), chewing tobacco 3- Addicting drugs in addition to above	
Score for initial assessment (%)		
Clinical Examination and Assessment		
General examination adequate including examination from head to toe, looking for signs of internal disease	1- No examination 2- Performs limited general examination 3- Performs a thorough general examination	
Checks that vital signs (temperature, respiratory rate, blood pressure, pulse) are recorded and attends to comfort of patient at rest	1- No recording of some vital signs; recording of some vital signs using appropriate method 2- Recording of all vitals and ensures patient comfort	
Systemic examination – cardiovascular system	1- No examination of the cardiovascular system 2- Limited cardiovascular examination 3- Thorough cardiovascular examination	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Systemic examination –respiratory system	1- No examination done 2- Examination not complete 3- Complete examination of the respiratory system.	
Systemic examination- abdomen	1- No examination 2- Limited abdominal examination 3- Complete and thorough examination of the abdomen	
Systemic examination –genital examination(when applicable)	1- No examination of genitalia 2- Limited inspection of male/ female external genitalia 3- Complete examination where indicated	
Systemic examination –CNS, peripheral & autonomic systems (where applicable)	1- No examination 2- Limited CNS examination 3- Complete examination of the nervous system	
Total score for examination section (%)		
Clinical Diagnosis		
Rational interpretation of clinical data	1- No interpretation of clinical data 2- Limited interpretation of clinical data relevant 3- Complete interpretation of clinical data	
Identifies the system affected	1- No identification of system affected 2- Able to identify the system affected with some difficulties 3- Easily identifies the system affected and able to narrow down to the specific organ affected	
Makes ***provisional / differential***	1- Not able to make a diagnosis	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
diagnosis	2- Able to make some relevant differential diagnoses but incomplete 3- Able to make a full diagnosis	
Total score for clinical diagnosis section (%)		
Investigation and interpretation assessment		
Requests for appropriate investigations for diagnosis	1- No/inappropriate tests asked 2- Has some rational in asking for appropriate tests 3- All relevant tests ordered	
Interpretation of results (current and previous)	1- No interpretation of results 2- Poor/basic interpretation of results 3- Comprehensive interpretation of results	
Total score for investigations and interpretation section (%)		
Treatment and Care		
Identifies the danger signs and acts on them	1- Misses the danger signs or does not act on them 2- Identifies the danger signs but does not act or acts inappropriately or incomplete action 3- Identifies and acts appropriately	
Specific management	1- No/ completely inappropriate treatment 2- Inadequate treatment 3- Adequate specific treatment	
Review of on-going care	1- No follow up plan 2- Inadequate monitoring of progress	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
	3- Adequate monitoring and follow up plan	
Long term follow up and advice	1- No follow up plan 2- Inadequate advice and follow up plan 3- Comprehensive follow up plan	
Exhibits proficiency in ***researching medical information*** related to care	1- Does not look up issues in literature 2- Shows some level of proficiency to look up issues 3- Knows how to look up and where to get clarification on important issues in a book/journal/newsletter/website	
Total score for clinical management section (%)		
Follow up Advice and Non-medical Patient Counselling		
Explains diagnosis to patient	1- No explanation of condition 2- Limited explanation for patient comprehension 3- **A**dequate explanation of condition	
Gives medical advice	1- No advice given/ or inappropriate advice 2- Limited advice on treatment and compliance 3- Comprehensive advise on treatment of condition	
Total score for follow up and non-medical advice (%)		
Review of Recording of Medical Information and Records		
Documentation accurate, complete and timely for every consultation including completion and appropriate medical forms.	1- Documentation not done 2- Partial documentation 3- Documentation complete	
Documentation of the history and physical finding results and	1- Documentation not done	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
management plans is clearly done	2- Documentation disorderly 3- Documentation complete and clear	
Total score medical records documentation section (%)		
Professional/ Interpersonal Skills		
Patient-centred (listens to patient's ideas and concerns) -	1- Does not welcome the patients and body language inappropriate 2- Welcomes patient and appropriate body language, but does not encourage patient 3- As above and encourages patient	
Uses team approach (shares information with colleagues, counsellor, social worker, nutritionist, and pharmacist, sanitary workers where necessary for an efficient interaction, lack of duplication of effort)	1- No coordination with team members 2- Limited **c**onsultation to the specialist physician when needed 3- Organises support systems, mentors colleagues	
Total score for professional/interpersonal skills (%)		
Overall score (%)		

Areas for improvement/current challenges:

Action Plan for person to improve identified areas for improvement:

Suggested date for next assessment: _____

Ministry of Health

Clinician Mentorship Tool - Surgery

Mentee Name/s: _____ **Mentee/s Qualifications:** _____

Site: _____ **Mentor:** _____

Month/Year: _____

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – **Not demonstrated /** No demonstration of skills, needs complete/full training

2 – **Partial demonstration:** Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – **Demonstrated***:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed, i.e., 'not applicable', to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; **50 – 75% -** requires further mentoring in specified technical area or specialty; **75% and above** – demonstrates good skills and does not require further mentoring in that area.

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Initial Assessment		
Chief complaints asked and recorded including the duration of the problem	*Chief complaints*- problems, which are of immediate, concern to patient. 1- No questions asked 2- Questions asked, but only related to positive symptoms 3- Questions asked relating to both positive and negative symptomatology	
Surgical history	1- Limited to chief complaints only, not dealing with co-morbid medical complaints 2- Past surgical history enquired into, past symptoms related to relevant symptoms, to be inquired 3- Past surgical history along with co-morbid medical conditions, previous surgical conditions/operations, and drug allergies recorded	
Past medical history taken relevant to chief complaints, co-morbid medical conditions	1- No complaints 2- Chief complaint enquired into, past symptoms related to relevant symptoms 3- Co-morbid medical conditions, along with, developmental and immunization history and drug allergies recorded	
Family history taken and recorded	1- Limited to details of individual patient only 2- Details of family history, spouse and children 3- Details of family history, co-morbid medical conditions and genetic disorders	
Drug history taken comprising of current/ previous medication, analgesics, side effects, toxicity,	1- Limited to current medication with some previous medication details	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
allergy, and herbal/traditional concoctions, blood transfusions, drug allergies	2- Current & recent past medications, dosage & duration elicited 3- Toxicity, side effects, compliance and adherence elicited in addition to above	
Personal/social history taken with emphasis on diet, addiction habits (smoking, alcohol, narcotics, etc.)	1- Limited to diet history, no personal habits enquired into 2- Details of smoking (type, number, duration), alcohol consumption (type, amount, duration) 3- Addicting drugs in addition to above	
Sexual history taken, previous and current STI's, contraceptive use, partner notification elicited in an empathetic, confidential setting	1- History of exposure elicited, no privacy or confidentiality 2- Details of sexual exposure (pre-marital, extra marital), history of STI's and treatment given (previous/current genital ulcer, discharge, bubo, etc.), contraceptive use 3- Privacy (utilises side room) and confidentiality (taking patient history in a confidential way) maintained with non-judgemental attitude (empathetic, body gestures)	
Documentation of history accurate, complete and timely for every consultation including completion and appropriate medical forms	1- Documentation not done 2- Partially complete or complete documentation of all findings 3- Documentation complete	
Total score for initial assessment (%)		

Professional/ Interpersonal Skills		
Patient-centred (listens to patient's ideas and concerns)	1- Welcomes the patients appropriately 2- Body language appropriate, empathetic (listens to patient) 3- Uses open ended questions, encourages patient	
Timely (doesn't rush patient and doesn't take too much time)	1- Inadequate time spent with patients 2- Adequate time spent with patients	
Privacy and confidentiality are maintained	1- No privacy/confidentiality maintained 2- Elicits sensitive history using appropriate open ended and close ended questions 3- Elicits sensitive history in all patients utilising side room (privacy)	
Practices ***universal precautions*** and advises on ***infection control*** procedures in work- station	1- No advice on infection control measures to patients 2- Advises and practices, hand washing, and use of gloves for individual patients 3- Ventilation adequate, segregation/disposal of waste, supervises and performs infection control procedures, aware of post exposure prophylaxis (PEP)	
Total score for interpersonal skills section (%)		

Clinical Examination and Assessment		
Vital signs recorded (temperature, respiratory rate, blood pressure, pulse)	1- No recording of vital signs in patients 2- Recording of some vitals using appropriate method 3- Recording of all vitals with identification of patients not comfortable at rest	
Checks weight of patient accurately and calculate percentage of weight gain/loss	1- No recording of weight done when required 2- Recording of weight when necessary 3- Recording of weight and head circumference in paediatric patients, as required and weight in adults and gain or loss noted	
General examination includes examination from head to toe, looking for signs of internal disease	1- No general examination done 2- Limited general examination 3- Thorough general examination, with privacy	
Systemic examination – cardiovascular system	1- No examination 2- Limited cardiovascular examination 3- Complete and thorough examination of the CVS	
Systemic examination –respiratory system, as related to the presenting complaint	1- No examination 2- Limited respiratory examination 3- Complete and thorough examination of the respiratory system	
Systemic examination- abdomen, as related to the presenting complaint	1- No examination 2- Limited abdominal examination 3- Complete and thorough examination of the abdomen	
Systemic examination –	1- No examination of genitalia	

genitourinary examination, as related to the presenting complaint	2- Inspection of male/ female external genitalia 3- Inspects and palpates genitalia and where applicable inserts sterile proctoscope /vaginal speculum (when available) in privacy (side room) and examination of urethra using urethroscope (as required)	
Systemic examination –CNS, peripheral & autonomic systems, Glasgow coma scale when necessary	1- No examination 2- Limited CNS examination 3- Complete and thorough examination of the CNS	
Systemic examination - musculoskeletal when required	1- Limited or no examination 2- Examination involves look, feel and moving site 3- Extra examination specific to site, e.g., collateral ligament test of knee / apprehension test for patella dislocation	
Total score for examination section (%)		
Clinical Diagnosis		
Recognises / makes ***provisional*** / ***differential diagnosis*** of presenting symptoms leading to correct clinical diagnosis including concurrent medical/ surgical/ obstetric conditions	1- No recognition of symptoms 2- Provisional /differential diagnosis relevant to presenting symptoms and signs of patient leading to diagnosis of opportunistic infections 3- Diagnoses co-morbid medical conditions, other medical/surgical/obstetric complications in addition to above	
Determines accurate ***stage of disease: stages /grades appropriately, e.g.,*** various cancers/fractures using appropriate criteria and record whether based on clinical or other means/methods such as histopathologic/ X-ray criteria	1- No staging of patients 2- Inadequate staging of without recording criteria used 3- Adequate staging with record of criteria upon which staging/ grading is based, every visit	
Total score for clinical diagnosis section (%)		

Laboratory Assessment		
Appropriately evaluates patients using laboratory tests to ***confirm clinical diagnosis***	1- No/inappropriate tests asked 2- Has some rational in asking for appropriate tests 3- All relevant tests ordered	
Checks results (current and previous) of laboratory and verify documentation, ***interpreted*** results correctly leading to appropriate response	1- No interpretation of results 2- Poor/basic interpretation of results 3- Comprehensive interpretation of results	
Total score for laboratory section (%)		
Clinical Care and Treatment		
Knowledge base is adequate to provide safe and complete care of patients	1- No/limited in decision making for patient care 2- Some patients may be treated partially 3- Complete attention to all patient's needs, appropriate drugs/ drug regimens and accurate dosing, and gives appropriate patient education	
Recognises need for ***acute care*** for life threatening complications and provides emergency treatment appropriately	1- Misses the danger signs or does not act on them 2- Identifies the danger signs but does not act or acts inappropriately or incomplete action 3- Identifies and acts appropriately	
Manages ***other co-morbid conditions***	1- No management of other co-morbid conditions/chronic illnesses 2- Incomplete management of chronic illness/co –morbid conditions 3- Management according to guidelines/seeks specialist	
Exhibits proficiency in ***researching***	1- No knowledge on looking up issues	

medical information / use of guidelines related to care	2- Shows some level of proficiency to look up issues 3- Knows how to look up and where to get clarification on important issues in a book/journal/newsletter/website	
Total score for clinical management section (%)		
Referral/Link to Other Health and Supportive Services and Follow up		
Seeks specialist advice, ***refers*** or ***links*** patient to appropriate health/supportive service	1- No discussion/ referral 2- No discussion but refers appropriately 3- Discusses reason for referral and refers appropriately	
Advises on clear ***plan*** for individual patient & allocates dates for follow up	1- No follow up plan 2- Inadequate advice and follow up plan 3- Comprehensive follow up plan	
Total score for follow up / referral section (%)		
Overall score (%)		

Areas for improvement/current challenges:

Action Plan for person to improve identified areas for improvement:

Suggested date for next assessment: _____

Ministry of Health

Integrated Management of Childhood Illness (IMCI) Mentorship Tool

Case Management Observation (2 months up to 5 years)

Mentee Name/s: _____ **Mentee/s Qualifications: _____**

Site: _____ **Mentor: _____**

Month/Year: _____

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – Not demonstrated / No demonstration of skills, needs complete/full training

2 – Partial demonstration: Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – Demonstrated*:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed i.e. 'not applicable', to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; 50 – 75% - requires further mentoring in specified technical area or specialty; 75% and above – demonstrates good skills and does not require further mentoring in that area.

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
General Information		
The mentee should record for all general information as follows: • Asks the age of the child, s/he or someone weighs or weighed the child, and s/he or someone measures or measured body temperature • Asks about the child's problems	*General Information*- age, weight, temperature, child's problems 1- Does not **r**ecord any of the four general information 2- Records some of the four general information 3- Records all of the four general information	
General Danger Signs		
The mentee should assess about all general danger signs as follows: • Asks whether the child is not able to drink or breast-feed, whether the child vomits everything and whether the child has had convulsions at home • Checks for lethargy or unconsciousness	1- Does not asks or check for any of the general danger signs 2- Asks and checks for some general danger signs 3- Asks for and looks for all four general danger signs	
ASSESSMENT FOR THE FOUR MAIN SYMPTOMS **Cough or Difficult Breathing**		
The mentee should ask about the first main symptom (cough or difficult breathing); if present, observe for the following: • Asks whether the child has cough or difficult breathing • If the child has cough or difficult breathing, asks the duration; counts the breath in one minute; checks whether the child has chest in-drawing (CI) {by lifting up shirt/dress}; considers whether the general danger sign is present when classifying and treats the child according to guidelines	1- Does not ask about cough or difficult breathing, or asks but does not assess, does not classify or treat the child according to guidelines 2- Asks about cough or difficult breathing , but only partially assesses, classifies and treats the child 3- Asks about cough or difficult breathing and comprehensively assesses, classifies and treats the child according to guidelines	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Diarrhoea		
The mentee should ask about the second main symptom (diarrhoea) if not part of the presenting problems; if present, observes the following: • Asks whether the child has diarrhoea; if the child has diarrhoea, asks for the duration, blood in stool • Checks whether the child is thirsty or drinking poorly when offered fluids, confirms with caretaker on sunken eyes • Pinches skin of the abdomen • Treats child according to guidelines	1- Does not ask about diarrhoea, or asks but does not assess, classify or treat the child according to guidelines 2- Asks about diarrhoea, but only partially assesses, classifies and treats the child 3- Asks about diarrhoea and comprehensively assesses, classifies and treats the child according to guidelines	
Fever		
The mentee should ask about the third main symptom (fever) if not part of the presenting problems; if present, observes the following: • Asks whether the child has fever; if the child had fever, asks for duration; checks for presence of stiff neck; orders or carries out rapid diagnostic testing (RDT); asks about measles in the past three months; undresses the child and looks for generalised rash of measles • Considers the general danger sign if present when classifying and treating the child according to guidelines	1- Does not ask about fever or asks but does not assess, classify or treat the child according to guidelines 2- Asks about fever but only partially assesses, classifies and treats the child 3- Asks about fever and comprehensively assesses, classifies and treats the child according to guidelines	

Ear problem		
The mentee should ask about the fourth main symptom (ear problem) if not part of the presenting problems; if present observes for the following: • Asks whether the child has an ear problem; if there is an ear problem, asks whether there is ear pain or ear discharge; if there is discharge, asks for duration and checks whether ear discharge is present • Looks for tender swelling behind the ear (Mastoiditis) and treats according to guidelines	1- Does not ask about an ear problem or asks but does not assess, classify and treat the child according to guidelines 2- Asks about an ear problem, but only partially assesses, classifies and treats the child 3- Asks about an ear problem and comprehensively assesses, classifies and treats the child according to guidelines	
Malnutrition		
The mentee must assess for malnutrition by doing the following: • Undresses child to look for visible severe wasting; checks for oedema of both feet; determines weight-for-age status and checks for growth faltering where applicable • Makes management decision /advice where needed according to guidelines	1- Does not assess for signs of malnutrition 2- Partially assesses, classifies and states management decision/advice where needed 3- Comprehensively assesses, classifies and states management decision/advice where needed according to guidelines	
Anaemia		
The mentee must assess for anaemia by doing for the following: • Checks the palms for pallor	1- Does not check for palm pallor and does not classify 2- Inappropriately assesses, classifies and states management decision/advice 3- Comprehensively assess, classifies and states management decision/advice where needed according to guidelines	

HIV/AIDS		
The mentee must assess for HIV infection by doing for the following: • Checks for HIV status of the mother and child from the under-five card where available; if the under-five card is not available or has no information, HW asks whether the mother and child have had an HIV test done • Checks for conditions which may suggest HIV infection, looks and feels for the signs which suggest HIV infection	1- Does not assess for HIV status 2- Partially assesses, classifies and states management decision/advice where needed 3- Comprehensively assess, classifies and states management decision/advice where needed according to guidelines	
IMMUNIZATION, VITAMIN A SUPPLEMENTATION		
Feeding Assessment for Children with Malnutrition, Anaemia, or Growth Faltering for Children Less than Two Years Old		
The mentee should assess feeding of eligible children as follows: • Asks whether the child is on breast milk; if child is breastfed, asks about how many times in 24 hours; asks whether the child takes other food or fluids; if child takes other food, health worker asks about how many times per day • Lists existing feeding problems (not exclusive breastfeeding ; breastfeeding< 8 times in 24 hours; no complementary foods given; gets < meals; bottle feeding; no active feeding; shares with others; eats less when sick; other)	1- Does not assess feeding of the eligible child 2- Partially assesses feeding of the eligible child 3- Comprehensively assesses feeding, lists existing feeding problems and states correct feeding recommendation /advice appropriately	

Mentee/Caretaker Interaction		
The mentee should do as follows: • Explains to the caretaker when to bring the child back for FOLLOW-UP and when to return IMMEDIATELY • Mentions any of the following signs: child becomes sicker; fevers persists; not able to drink or breast feed; breathing faster or there is difficult breathing; child becomes drowsy or difficulty to arouse; has bloody stool; diarrhoea persists	1- Does not explain to the caretaker when to bring the child back for FOLLOW-UP and when to return IMMEDIATELY 2- Partially explains to the caretaker when to bring the child back for FOLLOW-UP and when to return IMMEDIATELY 3- Comprehensively explains to the caretaker when to bring the child back for FOLLOW-UP and gives advice to the caretaker when to return IMMEDIATELY by mentioning at least two of the signs	
Overall score (%)		

Areas for improvement/current challenges:

Action Plan for person to improve identified areas for improvement:

Suggested date for next assessment: _____

Ministry of Health

Laboratory Mentorship Tool

Objectives:

1- Provide accurate information on all laboratory policies, guidelines and procedures
2- Perform laboratory tests proficiently, without error and in accordance with national standard operating procedure (SOP) guidelines
3- Follow ethical channels of conduct and communication in the workplace
4- Demonstrate analytical and decision making skills in laboratory practice
5- Practice safety at the workplace in accordance with established national laboratory safety guidelines
6- Perform relevant quality assurance procedures on all tests before their release

Mentee Name/s: _____ **Mentee/s Qualifications:** _____

Site: _____ **Mentor:** _____

Month/Year: _____

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – **Not demonstrated /** No demonstration of skills, needs complete/full training

2 – **Partial demonstration:** Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – **Demonstrated***:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed, i.e., 'not applicable,' to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; **50 – 75%** - requires further mentoring in specified technical area or specialty; **75% and above** – demonstrates good skills and does not require further mentoring in that area.

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Rational Use of laboratory Tests		
Receives and verifies the laboratory request forms from patients or representatives	1- Only checks laboratory requested forms and runs tests 2- Confirms patient details, date request was made and when specimens were collected 3- Verifies that clinical details are given and that they match with test requested and follows-up if necessary with the clinician for confirmation of clinical details and or test requested	
Provides counselling and encourages rational use of laboratory tests	1- No information provided to clinicians on rational use of laboratory tests 2- Discusses with clinicians/patients on the available tests, specimens required, time of collection, time it takes to perform the test and when the results will be ready (where a test is not available, advise on where specimen or patient can be referred to) 3- Discusses with clinicians/patients the results generated from the laboratory and also advise subsequent test that may help in diagnosis	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Prepares laboratory equipment, reagents, kits and consumables for performing laboratory tests according to the SOPs	1- Not aware of availability of SOPs guidelines for laboratory tests 2- Aware of availability of SOP guidelines and follows them when performing tests, labels reagents and specimens correctly 3- Laboratory SOPs and guidelines readily available; reagents and specimens appropriately and correctly labelled; and organises the laboratory working space neatly	
Completes accurate documentation of laboratory results	1- No documentation done 2- Documents laboratory results for profiles in one laboratory register 3- Documentation complete, for all laboratory tests in individual laboratory register for each test profile	
Total score for rational use of laboratory tests (%)		
Quality Assurance		

Knowledge and documentation on quality assurance activities done in the laboratory:
• Automated analysers for
  ○ Full blood count
  ○ Chemistry profiles
  ○ CD4 counting
• Rapid diagnostic tests for HIV, syphilis, TB and malaria
• Room and fridge temperature
• Monitoring proper storage of laboratory information
	1- No information and documentation on quality control activities done on performed laboratory tests
	
	2- Able to explain and show documentation on quality control activities done when performing some of the tests
	
	3- Clear explanation of quality control activities done when performing laboratory tests; clear and accurate documentation of quality control activities done and filed	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Knowledge base on quality assurance is adequate to provide quality laboratory results	1- No decision making for patient care 2- Incomplete attention to laboratory tests, failing quality control, releasing results despite failing quality control (QC) 3- Complete attention to all quality assurance activities, verifying all test results before releasing them from laboratory, troubleshooting causes of tests failing QC and ability to explain to clinicians/patients possible causes of QC failure and remedial measures	
Knows when to ***seek guidance*** from supervising biomedical scientist	1- Does not to seek guidance 2- Ask guidance when necessary from senior officers	
Exhibits proficiency in ***researching laboratory/medical information*** related to care	1- No/limited knowledge on looking up issues 2- Shows some level of proficiency to look up issues 3- Knows how to look up and where to get clarification on important issues	
Total score for quality assurance section (%)		
Stock Control And Inventory (Logistics Management)		
Receives laboratory commodities and other supplies from Medical Stores Limited (MSL)/ District Health Office (DHO) /or any other source	1- Commodities received without conducting visual inspection 2- Visually inspects packaged commodities and notes any damages, discrepancies on supply voucher/respiratory rates/reporting evaluation and monitoring (REMs)/usage reports 3- In addition to #2 above, updates inventory record and follows procedure for returning damaged, wrongly supplied/expired products back to MSL/DHO/ other source	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Stores laboratory commodities and other supplies	1- Stores products without following any good storage practices or guidelines 2- Follows at least key good storage guidelines and practices (FEFO, prevention of direct sunlight and heat, ready access to a fire extinguisher/bucket of sand, prevents water or humidity, keeps chemicals and food separate) 3- Follows at least 90% of all good storage guidelines and practices including all key guidelines as outlined in the standard operations manual	
Prepares and conducts a physical count	1- No physical count conducted/calculated balance recorded on stock control card 2- Follows some key practices including preparing and conducting a physical count at end of month, considers storage areas, updating records 3- Prepares for and conducts a physical count according to agreed-upon procedures including adjusting for unusable stock on stock control cards	
Inventory control	1- No stock control cards to record inventory or commodity usage 2- Uses improvised LMIS forms or standard LMIS forms not up-to-date, refers to job aids where necessary 3- Standard LMIS forms as per specific standard procedures used to document actual consumption/usage/issues; all standard LMIS forms updated according to standard procedures	
Prepares for and conducts stock status assessment according to agreed-upon procedures	1- No stock status assessment conducted 2- Is unable to determine the correct months of stock	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
	3- Is able to determine the months of stock accurately, refers to job aids where necessary, and takes appropriate action	
Orders laboratory commodities and other supplies from Logistics Management Unit/Medical Stores Limited/ DHO	1- Unable to complete accurate reporting and ordering forms 2- Completes some of the portions of the reporting and order forms 3- Completes all portions of the appropriate reporting and order forms correctly; refers to standard procedures manual where necessary	
Follows procedures for returning damaged or wrongly supplied products to suppliers	1- Does not follow procedures for returning damaged or wrongly supplied products to suppliers 2- Follows some of the procedures for returning damaged or wrongly supplied commodities 3- Completes all documents and follows procedures for returning damaged or wrongly supplied commodities	
Completes all relevant documentation and follows procedures for disposal of damaged, expired laboratory commodity and obsolete equipment	1- Does not follow procedures for disposal of expired/damaged products and obsolete equipment 2- Follows some procedures for disposal of expired damaged products and obsolete equipment 3- Completes all documents and follows all procedures for disposal of expired/ damaged commodities and obsolete equipment	
Total score for logistics management (%)		
Professional/ Interpersonal Skills		
Patient centred (listens to patient's ideas and concerns)	1- Welcomes the patient and offers seat to patient	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
	2- Body language appropriate, empathetic 3- Uses **o**pen ended questions, encourages patient	
Maintains ***privacy and confidentiality*** while providing laboratory services counselling	1- No privacy/confidentiality during specimen collection, counselling, giving results 2- Maintains confidentiality during specimens collection, counselling, giving results in an open place 3- Collects specimens, provides counselling, give results in a private place and maintains confidentiality	
Uses team approach (shares information with colleagues, e.g., nurses, counsellors, social workers, nutritionists, clinicians and other health workers where necessary for an efficient interaction to ensure quality service delivery)	1- No coordination /communication with team members 2- Consults senior laboratory personnel only 3- Consults and interacts with other health workers, mentors colleagues where necessary and appreciates team work	
Total score for professional/interpersonal skills (%)		
Overall score (%)		

Areas for improvement/current challenges:

Action Plan for person to improve identified areas for improvement:

Suggested date for next assessment: _____

Ministry of Health

Mentoring Tool for Nurses and Midwives

Mentee Name/s: _____ **Mentee/s Qualifications:** _____

Site: _____ **Mentor:** _____

Month/Year: _____

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – **Not demonstrated /** No demonstration of skills- needs complete/full training

2 – **Partial demonstration:** Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – **Demonstrated***:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed, i.e., 'not applicable,' to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; **50 – 75%** - requires further mentoring in specified technical area or specialty; **75% and above** – demonstrates good skills and does not require further mentoring in that area.

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Basic Client-Nurse Interaction (admission, assessment and initiation of nursing care plan)		
Welcomes the client/relative(s) in a courteous and respectful manner	1- Does not welcome patient 2- Welcomes client but not in respectful manner 3- Welcomes client in courteous and respectful manner	
Ensures adequate privacy for the client	1- No privacy ensured 2- Some privacy provided 3- Adequate privacy provided for client	
Asks about complaints	1- No questions asked 2- Asked questions but inappropriate 3- Asked client appropriate questions	
Checks the client's vital signs	1- No vital signs checked 2- Recorded some vital signs 3- Recorded all the Vital signs checked and recorded accurately (TPR, BP)	
Performs physical assessment appropriately according to client needs as necessary	1- No assessment done 2- Incomplete physical examination according to protocols 3- Complete physical examination of the client according to patient needs	
Records results of the physical assessment in the clients documents	1- Documentation not done 2- Partially complete documentation of findings 3- Documentation complete of findings	
Initiates appropriate investigations based on results of physical assessment/ doctors' advice? (e.g. blood test, urinalysis, stool test etc.)	1- No investigations initiated 2- Incorrect investigations initiated/ advice not carried out 3- Correct investigations initiated and clinician's advice carried out	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Initiates a nursing care plan based on the nursing assessment	1- No nursing care plan initiated 2- Nursing care plan initiated but not based on nursing assessment 3- Nursing care plan initiated based on nursing assessment	
If an appropriate opportunity arises, uses ***opportunities for counselling and appropriate health teaching***	1- No health information or communication provided 2- Did not take opportunity to provide information or communicate 3- Used opportunity appropriately to provide information or communicate	
Discusses follow-up care with the client, including follow-up visits or referrals to other sites, if appropriate	1- No follow up care discussed 2- Follow up care discussed but not complete 3- Follow up care and referrals to other site discussed as appropriate	
Total score for basic nurse-client interaction (%)		
	Technical Competence with Nursing Procedures	
Follows nursing guidelines for performing procedures	1- Guidelines not followed. 2- Limited guidelines followed 3- Nursing guidelines adequately followed	
Emergency care Ensures that the emergency trolley/tray had the required medications, in the right amounts, and that none were expired	1- No emergency trolley 2- Emergency trolley available but poorly stocked/ expired drugs 3- Trolley adequately stocked and drugs not expired	
Responds adequately and appropriately to emergencies	1- No response 2- Delayed response 3- Responded adequately	
Total score for technical competence for nursing procedures (%)		

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Family Planning		
Assesses the client's current reproductive status (e.g., age, parity, marital status)	1- No assessment done 2- Limited assessment 3- Complete and appropriate assessment done	
Gives explanation on the available methods for the client to make an informed choice	1- No explanation given 2- Limited information given 3- Adequate information given	
Gives the chosen method to client or refers where appropriate	1- Did not give/ refer client 2- Gave but not the chosen method 3- Gave the chosen method/ referred appropriately	
Total score for family planning (%)		
Antenatal Care		
Welcomes the client/relative(s) in a courteous and respectful manner	1- Did not welcome client 2- Limited welcome 3- Welcomed patient in courteous/ respectful manner	
Ensures adequate privacy for the client	1- No privacy 2- Limited privacy provided 3- Adequate privacy provided	
Collects full history and conducts comprehensive examination on the client from head to toe including palpation and record (CVS, TPR, BP, CNS, oedema, breast, anaemia, varicose veins, vaginal discharge and	1- No history taken and examination not comprehensive 2- Limited history taken but comprehensive examination not done	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
other abnormalities)	3- Adequate history taken and comprehensive examination conducted/documented.	
Carries out the necessary investigations, e.g., urinalysis, Hb estimation, grouping and RH	1- Did not carry out necessary investigations 2- Carried out some investigations 3- All necessary investigations carried out	
Gives the necessary counselling and test for HIV	1- No counselling done 2- Limited counselling done 3- Comprehensive counselling/ HIV testing done	
Gives the necessary immunizations and medication	1- No immunisations and medication given 2- Immunisation given but no necessary medication given 3- All the necessary immunisations and medication given	
Total score for antenatal care (%)		
Intra-partum Care		
Identifies particulars of client	1- No gestation a age, parity, gravida given 2- Limited mention of above particulars 3- Complete identification of client's gestation age, parity, gravida	
Determines history of this labour	1- Onset of labour, rupture of membranes, any vaginal bleeding, perception of foetal movements not elicited 2- Limited information of the above given 3- Comprehensive information related to this labour elicited	
Status of current pregnancy	1- Antenatal card not reviewed for any problems 2- Antenatal card reviewed but some information not applied to patient's needs 3- Antenatal card reviewed and appropriate action taken where applicable	
Review s of birth plan	1- Birth plan not reviewed 2- Birth plan reviewed but not discussed with client 3- Plan reviewed and discussed with client and appropriate action taken	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Reviews past obstetric history	1- Past obstetric history relating to previous delivery, difficult labours, still births not reviewed 2- Past obstetric history reviewed, but no appropriate action taken 3- Past obstetric history reviewed and appropriate action taken	
Takes vital signs	1- No vitals taken, temp, BP, pulse, RR 2- Some vitals recorded 3- All vitals including urinalysis recorded	
Performs obstetric examination	1- Fundal height, presentation, lie, liquor volume, foetal heart rate not done 2- Some of the parameters done 3- Complete performance of above parameters	
Performs vaginal examination	1- Not done to assess stage of labour, state of membranes, presenting parts, and adequacy of pelvis 2- Some parameters not assessed 3- Complete performance of above parameters	
Monitors progress of labour	1- Partograph not opened to monitor progress of labour 2- Partograph opened but incorrect/incomplete entries 3- Partograph opened ,with correct entries and appropriate monitoring	
Second stage of labour	1- Clean/safe delivery protocols not followed 2- Some clean and safe delivery protocols followed 3- All clean and safe delivery protocols followed	
Third stage of labour	1- No active third state of labour observed 2- Not all steps/protocols followed in the active third stage 3- All steps/protocols followed in the active third stage	
Documents	1- No documentation on events of labour 2- Incorrect/incomplete documentation 3- Complete documentation of all events of labour	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Gives feedback to client/relative(s)	1- No feedback given on the events of labour 2- Incorrect/Incomplete feedback given 3- Complete feedback given on the events	
Conducts postnatal care according to guideline	1- No postnatal care given 2- Conducted postnatal examination but not according to standard guidelines 3- Conducted postnatal examination according to guidelines	
Total score for intra-partum care (%)		
Pre-operative Care		
Assesses the client's physical and psychological needs adequately	1- No assessment done 2- Some assessment done 3- Complete assessment done	
Explains the condition and the operation adequately to the client/ relative(s) and allow them to ask questions	1- No explanation done 2- Some explanation done 3- Complete explanation and allowed client/relatives to ask questions	
Ensures that a valid, written and informed consent was obtained from the client/relative(s)	1- No consent obtained 2- Incomplete consent obtained 3- Complete and accurate consent obtained	
Carries out ***client's physical preparation according to standard guidelines and documented,*** e.g., client starved, trimmed hair, dentures/jewellery/ nail polish removed, catheter, cannula inserted, etc.	1- No preparation done 2- Some preparations done 3- Complete preparation done	
Ensures that necessary investigations were done and results available prior to surgery, e.g., Hb, grouping and cross match, BT, CT, X-ray, urinalysis etc.	1- Did not ensure necessary investigations have been done 2- Ensured that some necessary investigations have been done 3- Ensured all necessary investigations have been done	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Administers prescribed pre-medication drug(s) as advised and record accurately	1- Did not administer pre-medication 2- Administered some pre-medication 3- Administered all the pre-medication	
Gives complete detailed handover to the theatre nurse	1- No handover was given 2- Inadequate handover given 3- Complete and detailed handover given	
Total score for pre-operative care (%)		
Post-operative Care		
Solicits a complete handover from the theatre nurse/anaesthetist	1- Did not solicit handover from theatre nurse/anaesthetist 2- Some handover from theatre nurse 3- Complete handover from theatre nurse	
Carries out post-operative nursing procedures as per protocols and doctor's advice (e.g., vital signs, wound care, care of tubes, fluid therapy, analgesia, blood transfusion, etc.)	1- No post-operative procedures done Some post-operative procedures done 2- Complete and appropriate post-operative procedures done	
Recognises post-operative complications and acts appropriately/reports	1- Did not recognise post-operative complications 2- Recognised some post-operative complications but did not act./report 3- Recognised all post-operative complications and acted appropriately/reported	
Total score for post-operative care (%)		
Care of Patient with Fever or Coma		
Correctly identifies febrile (fever) condition and takes appropriate measures to reduce fever	1- No identification done 2- Identified but did not take appropriate measures 3- Identified and took appropriate measures	
Determines the patient's level of consciousness using the Glasgow Coma scale appropriately and interpreted findings	1- Did not use Glasgow coma scale 2- Used Glasgow coma scale but did not interpret the findings 3- Used and interpreted findings correctly	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Initiate sappropriate nursing care plan and carries out nursing interventions accurately, e. g., provides oral care, bed baths, 2 hourly turnings, feeding, etc.	1- Did not initiate nursing care plan Initiated nursing care plan but did not carry out interventions 2- Initiated nursing care plan and carried out all the interventions	
Total score for care of febrile or comatose patient (%)		
Infection Prevention		
Practices universal precautions of infection prevention (IP)	1- Did not practise 2- Some IP precautions practiced 3- All universal precautions practiced	
Takes the opportunity to ***discuss infection prevention practices*** that the client can follow after leaving the site	1- No discussion done 2- Some discussion done 3- Infection prevention practices discussed with client	
Total score for infection prevention section (%)		
Overall score (%)		

Areas for improvement/current challenges:

Action Plan for person to improve identified areas for improvement:

Suggested date for next assessment: _____

Ministry of Health

Clinician Assessment Tool – Paediatric Care

Mentee Name/s: _____ **Mentee/s Qualifications:** _____

Site: _____ **Mentor:** _____

Month/Year: _____

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – **Not demonstrated:** No demonstration of skills, needs complete/full training

2 – **Partial demonstration:** Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – **Demonstrated***:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed, i.e., 'not applicable,' to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; **50 – 75% -** requires further mentoring in specified technical area or specialty; **75% and above** – demonstrates good skills and does not require further mentoring in that area.

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Initial Assessment		
Asks about ***chief complaints*** and records including the duration of the problem	1- No questions asked 2- Questions asked, but only related to positive symptoms 3- Questions asked relating to both positive and negative symptomatology	
Takes and records history of present illness	1- Elaboration of chief complaints only (development of symptoms) 2- Sequential, chronological elicitation of symptoms using open ended and close ended questions (review of presenting system) 3- Symptom analysis, positive & negative symptoms, all major systems (CVS, RS, abdomen, CNS) covered, all symptoms analysed in chronological order (systemic review)	
Takes birth and past medical history with emphasis on birth weight, HIV status of the child as indicated on the under-five card and other possible co-morbidities	1- Limited to chief complaints only, not dealing with co-morbid medical complaints or HIV exposure status 2- Co-morbid medical conditions (HIV, sickle cell anaemia, epilepsy, tuberculosis) enquired into, past symptoms related to relevant symptoms and HIV exposure status 3- Co-morbid medical conditions, along with previous surgical conditions, blood transfusions , drug allergies recorded and HIV exposure status	
Takes immunization and developmental history including nutrition	1- No mention of either immunisations received or developmental milestones attained 2- Mere mention of immunisation status, current developmental milestone attained	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
	3- Actual under-five card checking for anthropometric measurements (plus OI prophylaxis, PMTCT interventions and ART if indicated), and eliciting developmental milestones	
Takes and records family history	1- Limited to details of individual patient only 2- Details of family history, parents and siblings 3- Above details including paediatric deaths, co-morbid medical conditions and genetic disorders	
Asks about drug history comprising current, previous medication, side effects, toxicity, allergy, and herbal/traditional remedies	1- Limited to current medication with some previous medication details 2- Current and recent past medications, dosage and duration elicited 3- Toxicity, side effects, compliance and adherence elicited in addition to above	
Asks about and records socio-economic background	1- No mention at all 2- Mention of it with no attempt to relate to current condition 3- Mention of it with establishing possible interaction with current ailment	
Documents accurate and complete consultation sessions including completing appropriate medical forms	1- Documentation not done 2- Partial documentation of all findings 3- Complete documentation of all findings	
Total score for history taking section (%)		

Professional/ Interpersonal Skills		
Patient-centred (listens to patient/guardian's ideas and concerns)	1- Does not welcome and/or offer seat to patient 2- Welcomes patient but has inappropriate body language 3- Welcomes patient, has appropriate body language and encourages patients	
Timely (doesn't rush patient and doesn't take too much time)	1- Inadequate time with patients 2- Adequate time with patients	
Privacy and confidentiality are maintained while taking sensitive histories	1- No elicitation of sensitive history/risk taking behaviour 2- Limited **e**licitation of sensitive history using appropriate open ended and close ended questions whilst being mindful about the child's presence 3- Comprehensive elicitation of sensitive history using appropriate open ended and close ended questions, whilst being mindful about the child's presence	
Exhibits good bedside manners while examining patient	1- No dialogue with patient/guardian and quick, aimless assessment 2- Examines, in addition to above 3- Keeps eye contact with patient whilst verbally reassuring, thorough and gentle	
Practices ***universal precautions for infection prevention/control*** in work-station	1- No practice of infection prevention/control measures 2- Limited practice and advice on infection prevention/control measures 3- Comprehensive practice and advice on infection prevention/control measures	
Total score for professional/interpersonal skills (%)		

Clinical Examination and Assessment		
Checks that vital signs (temperature, respiratory rate, blood pressure, pulse) are recorded and attends to comfort of patient at rest	1- No recording of vital signs in few patients 2- Limited recording of some vital signs using appropriate method 3- Comprehensive recording of all vitals with identification of patients not comfortable at rest	
Checks and records anthropometric measurements (weight, height and head circumference in young children) accurately and calculates BMI and Z scores	1- No checking or recording of weight, height and head circumference 2- Checks and records some anthropometric measurements 3- Checks and records all anthropometric measurements	
Conducts adequate general examination including examination from head to toe	1- No examination 2- Limited general examination (some signs) 3- Comprehensive general examination (all signs)	
Systemic examination – cardiovascular system	1- No cardiovascular examination 2- Limited cardiovascular examination 3- Comprehensive cardiovascular examination	
Systemic examination –respiratory system	1- No respiratory examination 2- Limited respiratory examination 3- Comprehensive respiratory examination	
Systemic examination- abdomen	1- Limited to simple inspection of abdomen 2- Palpation of abdominal quadrants systematically, auscultation of bowel sounds, free fluid (using appropriate methods) and identification of organomegaly (when appropriate)	

	3- In addition to above, examination of external genitalia and per rectal examination (when appropriate)	
Systemic examination –CNS, peripheral and autonomic systems	1- No CNS examination 2- Limited CNS examination 3- Comprehensive CNS examination	
Total score for examination section (%)		
Clinical Diagnosis and Laboratory Assessment		
Makes provisional / differential diagnosis	1- No diagnosis 2- Incorrect /incomplete diagnosis made 3- Correct and complete diagnoses noted	
Uses laboratory results for efficient patient's management (e.g., Hb, MCV, urea, etc.)	1- Makes no use of / cannot interpret results 2- Limited use of laboratory results 3- Interprets and efficiently uses laboratory results	
Total score for clinical diagnosis laboratory assessment section (%)		
Clinical Care and Treatment		
Knowledge base is adequate to provide safe and complete care of patients	1- No decision making for patient care 2- Limited knowledge base for care of patients 3- Adequate knowledge base for complete patient care	
Recognises when persons need ***acute care*** for life threatening complications and admit /provides emergency care immediately	1- No recognition or action taken 2- Limited recognition and action 3- Appropriate complete measures	
Knows when to ***seek guidance*** from supervising clinician	1- Does not seek guidance 2- Seeks appropriate guidance when necessary	

Identifies drug side effects, drug-drug interaction	1- No attempt to assess for side effects, interactions or treatment failure 2- Limited assessment and management of common drug side effects 3- Complete assessment of drug side effects including drug-drug interaction and treatment failure	
Exhibits proficiency in ***researching medical information*** related to care	1- No knowledge on looking up issues 2- Shows some level of proficiency to look up issues 3- Knows how to look up and where to get clarification on important issues	
Total score for clinical management section (%)		
Nutrition Advice		
Describes local sources of nutritious food, drug- food interactions if any	1- No advice at all 2- Advises on local sources of nutritious food 3- Above + advises on drug –food interactions if any, emphasises on adherence related to meals	
Advises on breastfeeding, infant and young child feeding to caregivers	1- No advice given 2- Limited advice on breastfeeding and infant and young child feeding including the context of HIV 3- Comprehensive advice on breastfeeding, infant and young child feeding including the context of HIV	
Total score for nutrition section (%)		

Referral/Link to Other Health and Supportive Services and Follow up		
Seeks specialist advice, refers or links patient to appropriate health/supportive service care	1- No discussion/ referral 2- No discussion but refers appropriately 3- Discusses at length about reason for referral and refers appropriately	
Advises on ***clear plan for individual patient*** and allocates dates for follow up (if necessary)	1- No care plan 2- Advises on care plan but does not provide information on follow up issues 3- Advises on care plan and provides information on follow up issues	
Total score for follow up / referral section (%)		
Overall score (%)		

Areas for improvement/current challenges:

Action Plan for person to improve identified areas for improvement:

Suggested date for next assessment: _____

Ministry of Health

Pharmacy Mentorship Tool

Provider Name: _____ **Provider Qualifications: _____**

Site: _____ **Supervisor: _____**

Month/Year: _____

Please summarize Provider's skills using codes given below:

Please summarize mentee's skills by putting a circle around the appropriate code number. The codes are given below:

1 – **Not demonstrated /** No demonstration of skills, needs complete/full training

2 – **Partial demonstration:** Demonstrates some strengths/skills in area, needs to strengthen skills in some areas

3 – **Demonstrated***:* Demonstrates excellent strengths/skills in this area

Where the stems provide for only two options to rate a mentee's skills (i.e., 1 and 2), then the mentee should be rated as follows:

1 – Not Demonstrated*:* (refer to section above for details)

2 – Demonstrated*:* (refer to section above for details)

Please use the "comments" column to note key observations to be discussed later with the provider. In addition, this space should be used to record explanations for why recommended practices were not followed, i.e., 'not applicable,' to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by you to the mentee.

Overall score interpretation:

<50% - requires further intensive mentoring or needs complete/full training in particular area; **50 – 75% -** requires further mentoring in specified technical area or specialty; **75% and above** – demonstrates good skills and does not require further mentoring in that area.

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Initial Assessment		
Pharmaceutical Care (pharmacy/dispensing to patients)		
Receives and validates prescriptions from patients or representatives	1- Only checks prescribed medicines and dispenses 2- Confirms prescriber details, date and medicine prescribed 3- Verifies authenticity of the prescription and follows-up if necessary with the prescriber for confirmation of prescription validity	
Stresses 100% ***adherence***	1- No information provided to patients on the importance of adherence 2- Explains adherence with the help of tools such as treatment cards (TB, ART, family planning medicines, etc.) 3- Explains adherence with the help of tools such as treatment cards (TB, ART, family planning, etc.) and explains goal (s) of therapy, emphasizing treatment reminders and the importance of treatment supporters	
Provides medication counselling and encourages rational use of medicines	1- No information provided to patients/supporters on medicines use 2- Discuss with patient or representative medicine plan (right dose, right time, right frequency, right duration) 3- Discusses with patient or representative the therapeutic plan (right dose, right time, right frequency, right duration)and in addition, discusses major side effects and how to handle them, drug interactions, completing course and where necessary, liaises with prescriber	

Demonstrated Skills/Tasks	Performance Rating (circle appropriate code)	Comments
Prepares medicines for issue to patients or representatives using correct packaging material and complete legible labelling	1- Incomplete labelling and wrong packaging material 2- Right packaging and incomplete labelling or wrong packaging and complete labelling 3- Packages medicines correctly, clearly legible and correct labels	
Dispenses medicines to patients or representatives with clear instructions	1- Dispenses the medicines without instructions 2- Dispenses medicines without confirmation of initial instructions 3- Dispenses after patient repeats correct instructions	
Documents accurately and completely medicines	1- No documentation done 2- Partially complete documentation of all medicines dispensed and drugs not dispensed 3- Documentation complete for all medicines dispensed	
Total score for Pharmacy/Dispensing to Clients (Pharmaceutical Care)		

Clinical Pharmacy		
Knows how to identify common medicine-related morbidity conditions (Pharmaco-vigilance)	1- Unable to state common medicine related conditions 2- Ability to identify common medicine induced morbidity conditions 3- Ability to identify and manage common medicine-related morbidity conditions	
Stresses well the severity of the condition and determines the level of intervention required	1- Not able to assess 2- Assesses but without intervention, e.g., referral 3- Assess and provides appropriate interventions	
Knowledge base is adequate to provide pharmaceutical care of patients	1- No /limited in decision making for patient care 2- Incomplete attention to all patient's needs, dispenses appropriate drugs/ drug regimens and accurate dosing, and gives appropriate patient education 3- Complete attention given to all patient's needs, dispenses appropriate drugs/ drug regimens and accurate dosing, and gives appropriate patient education	
Identifies clinical, medicine side effects, drug-drug interaction and treatment failure	1- No attempts to identify side effects, interactions or treatment failure 2- Limited assessment and management of common drug side effects 3- Does complete assessment and identifies drug side effects including drug-drug interaction and treatment failure	
Assesses and identifies adverse drug Reactions and timely reports appropriately	1- No attempts to assess and identify adverse drug reactions and therefore no appropriate action. 2- Assesses and identifies adverse drug reactions but does not report timely and appropriately.	

	3- Does complete assessment and identifies adverse drug reactions and reports timely and appropriately.	
Knows when to seek guidance from supervising pharmacist.	1- No attempts to seek guidance from supervising pharmacists as necessary. 2- Seeks guidance from supervising pharmacists but does not respond appropriately to the advice. 3- Seeks guidance from supervising pharmacist and responds appropriately to advice.	
Exhibits proficiency in ***researching pharmaceutical/medical information*** related to care.	1- No/limited knowledge on looking up issues 2- Shows some level of proficiency to look up issues 3- Knows how to look up and where to get clarification on important issues in a book/journal/newsletter/ website	
Total score for clinical pharmacy section (%)		

Stock Control And Inventory (Logistics Management)		
Receives drugs and other supplies from Medical Stores Limited/ DHO / or any other source	1- Commodities received without conducting visual inspection 2- Visually inspects packaged commodities and notes any damages, discrepancies on supply voucher/respiratory rates/reporting evaluation and monitoring/usage reports 3- In addition to #2, updates inventory record and follows procedure for returning damaged, wrongly supplied/expired products back to MSL/DHO/ other source	
Stores medicines and other supplies	1- Stores products without following any good storage practices or guidelines 2- Follows at least key good storage guidelines and practices (FEFO, prevention of direct sunlight and heat, fire extinguisher/bucket of sand, prevents water or humidity, keeps chemicals and food separate) 3- Follows at least 90% of all good storage guidelines and practices including all key guidelines as outlined in standard operations manual	
Prepares and conducts a physical count	1- No physical count conducted/calculated balance recorded on stock control card 2- Follows some key practices including preparing and conducting a physical count at end of month, considers storage areas, updating records 3- Prepares for and conducts a physical count according to agreed-upon procedures including adjusting for unusable stock on stock control cards	

Inventory control	1- No Stock Control Cards to record inventory or commodity usage 2- Uses improvised LMIS forms or standard LMIS forms not up-to-date, refers to job aid where necessary 3- Standard LMIS forms as per specific standard procedures used to document actual consumption/usage/issues; all standard LMIS forms updated according to standard procedures	
Prepares for and conducts stock status assessment according to agreed-upon procedures	1- No stock status assessment conducted 2- Unable to determine the correct months of stock 3- Able to determine the months of stock accurately, refers to job aid where necessary, and takes appropriate action	
Orders drugs and other supplies from Logistics Management Unit/Medical Stores / DHO	1- Unable to complete accurately reporting and ordering forms 2- Completes some of portions of the reporting and order forms 3- Completes all portions of the appropriate reporting and order forms correctly; refers to standard procedures manual where necessary	
Follows procedures for returning damaged or wrongly supplied products to suppliers	1- Does not follow procedures for returning damaged or wrongly supplied products to suppliers 2- Follows some of the procedures for returning damaged or wrongly supplied commodities 3- Completes all documents and follows procedures for returning damaged or wrongly supplied commodities	

Completes all relevant documentation and follows procedures for disposing drugs	1- Does not follow procedures for disposal of expired/damaged products 2- Follows some procedures for disposal of expired products 3- Completes all documents and follows all procedures for disposal of expired/ damaged commodities	
Total score for logistics management (%)		
Professional/ Interpersonal Skills		
Patient centred (listens to patient's ideas and concerns)	1- Does not pay any attention to the patient, verbally nor with appropriate body language 2- Expresses appropriate verbal but inappropriate body language to some patients 3- Displays appropriate verbal and body language to all patients	
Timely (doesn't rush patient and doesn't take too much time)	1- Rushes patient without taking time to explain 2- Does not rush patients, however, does not give clear instructions to some patients 3- Time spent per client is appropriate to the condition or situation	
Maintains ***privacy and confidentiality*** while providing medication counselling	1- No privacy/confidentiality during medication counselling 2- Maintains confidentiality while providing medication counselling in an open place 3- Provides medication counselling in a private place and maintains confidentiality for all patients	
Uses team approach (shares information with colleagues, i.e., nurses, counsellors,	1- No coordination /communication with team members	

social workers, nutritionists, clinicians and other health workers, where necessary for an efficient interaction to ensure quality service delivery)	2- Consults senior pharmacy personnel only 3- Consults and interacts with other health workers, mentors colleagues where necessary and appreciates team work	
Total score for professional/interpersonal skills (%)		
Overall score (%)		

Areas for improvement/current challenges:

Action Plan for person to improve identified areas for improvement:

Suggested date for next assessment: _____

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